MINISTRY OF HEALTH SERVICES

A NEW ERA
UPDATE

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Ministry of Health Services

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For more information on the British Columbia Ministry of Health Services, contact

Communications Branch
PO BOX 9650 Stn Prov Govt
Victoria, BC V8W 9P2
Telephone: 250 952-3456

or visit the B.C. Government's Web site at www.gov.bc.ca

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INTRODUCTORY NOTE – A YEAR IN TRANSITION

The Government of British Columbia and its ministries are committed to reporting on performance. The *Budget Transparency and Accountability Act* (BTAA), as amended in August 2001, provides the legislative framework for a regular cycle of planning, reporting and accountability. Under the BTAA, ministries are responsible for producing three-year service plans (previously called performance plans), which are updated yearly, and annual service plan reports (formerly called performance reports). The amended BTAA takes effect beginning with the 2002/03 fiscal year. The first three-year service plans, covering the period 2002/03 to 2004/05, were released with the provincial budget on February 19, 2002.

This annual report relates to the previous fiscal year, covering April 1, 2001, to March 31, 2002. This was a transition year, with a new government sworn into office on June 5, 2001. On that day, there was an extensive reorganization of ministries, which were given significant new policy direction and tasked with the responsibility for implementing the government's *New Era* commitments. Later in the year, ministries proceeded through the core services review, which refined the mandates of ministries and identified the strategic shifts required to move government toward its long-term objectives.

This report provides an update on all that activity and also provides a report on performance, approaching the model provided by the BTAA as closely as is possible in the circumstances. An annual report would normally relate back to a preceding plan and report on the results achieved compared with the intentions outlined in that plan. In this case, the preceding plan was produced before the adoption of the significant changes outlined above, and as noted, this ministry has been significantly reorganized, and policies and priorities have changed. This limits the extent to which performance information as described in the previous plan is useful.

Consequently, this report sets out the ministry's redefined role and the services it provides, and – within the context of its goals and objectives as they evolved through the year – describes the achievements of the ministry and the performance targets being used to measure success.

ACCOUNTABILITY STATEMENT

The 2001/02 Ministry of Health Services Annual Report was prepared under my direction and I am accountable for the results the ministry achieved since June 5, 2001. This report describes progress made in this first year on the government's New Era commitments, which are to be addressed by May 17, 2005.

Honourable Colin Hansen
Minister of Health Services
June 28, 2002

MINISTERS OF STATE ACCOUNTABILITY STATEMENTS

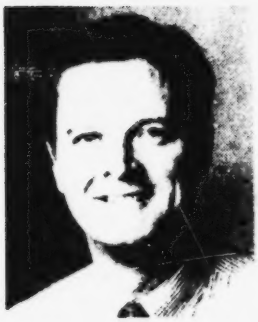
I am the Minister of State for Mental Health and, as such, am accountable for the basis on which that portion of the annual report was prepared and for the results achieved since June 5, 2001.

Honourable Gulzar Cheema
Minister of State for Mental Health
June 28, 2002

I am the Minister of State for Intermediate, Long Term and Home Care and, as such, am accountable for the basis on which that portion of the annual report was prepared and for the results achieved since June 5, 2001.

Honourable Katherine Whittred
Minister of State for Intermediate, Long Term and Home Care
June 28, 2002

MESSAGE FROM THE MINISTER OF HEALTH SERVICES



I am pleased to present the 2001/02 Annual Report: A New Era Update for the Ministry of Health Services.

When our new government was sworn into office in June 2001, the Ministry of Health Services was given the responsibility of implementing our New Era commitments: renewing our health care system, developing innovative solutions, and putting a priority on meeting the needs of patients. Health care is all about people – the British Columbians who receive health services across the province, the health professionals who discuss the treatment options for their patients, and the families and friends who visit and support an individual in care. It is the people that our ministry has focused on during the past year – a challenging transition year.

The New Era commitments address complex challenges in B.C.'s health care system such as human resources, hospital facilities, intermediate and long-term care facilities, and technology and medical equipment. These are all aimed at improving the delivery of services to patients. We have put a new focus on mental health and home and community care by expanding choices and providing more appropriate care to patients. In all, we have implemented or are well on our way to implementing more than half of our New Era commitments.

The Ministry of Health Services' budget increased by $1.1 billion to $9.5 billion in 2001/2002. Over the last decade, health spending has increased from about 33 per cent to almost 39 per cent of the total provincial budget in B.C. Clearly, spending increases of this magnitude are simply not sustainable in the long-term, underscoring the need for a better way to manage health care resources.

We have listened to British Columbians, health care providers and other partners on how to save our public health care system. Our government hosted a Dialogue on Health with health professionals, administrators and other experts to identify new solutions to improve patient care. Our government also initiated the Select Standing Committee to tour the province and receive feedback on changes needed for the health system, as reflected in the Patient's First report. We understand that British Columbians want strong leadership, accountability and a sustainable health system for the future.

The Ministry of Health Services is working with our health care partners to develop innovative approaches to achieve our vision of a health system that ensures high quality public health care services that meet patients' needs, where they live and when they need them. We are working closely with the Ministry of Health Planning to establish provincial access standards and guidelines for emergency, acute care and specialty services. We are implementing performance agreements and three-year funding

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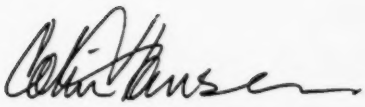
agreements with health authorities. These will help measure the performance of our health system, enhance accountability to the public and government for health dollars spent, and ensure patients receive the care they need.

From an extensive Electronic Health Record project that will change the way we all share and use health information, to new province-wide strategies for delivering patient care for everything from chronic disease management to mental health, we are moving towards a new era of excellence in health care.

This annual report enables the public and our health care partners to understand the goals, vision, priorities and achievements that we have made during the 2001/2002 fiscal year. This report presents key events and changes made in B.C.'s health care system and the ministry's role and services. It also details the ministry's progress on each of the New Era commitments relating to its mandate.

I would like to thank all the health care providers and other partners in ensuring patients receive the care they need. Our government is committed to working together to achieve our vision of health care in British Columbia.



Honourable Colin Hansen
Minister of Health Services

MESSAGE FROM THE MINISTER OF STATE FOR MENTAL HEALTH

Our government is committed to improving mental health services in British Columbia. Premier Gordon Campbell created my position as Minister of State for Mental Health to ensure that mental health care is on the provincial health care agenda. We have given mental health a voice at the Cabinet table.

Over the past year, the Ministry of Health Services has taken a number of steps towards achieving our New Era commitments to provide high quality, patient-centred care.

We made a New Era commitment to fully fund and implement B.C.'s Mental Health Plan. To fulfill that commitment, we recently announced a $263-million investment over the next six years. This funding will be used to enhance community services and build new facilities throughout the province. We will move away from the institutional treatment of those with a mental illness to a system that cares for people in the appropriate setting – close to their communities and loved ones. These new facilities will be in home-like settings where patients can receive the appropriate level of care for their individual needs.

The Ministry of Health Services and the Ministry of Children and Family Development are reviewing Child and Youth Mental Health Services to develop a provincial child and youth mental health plan. Our goal is to enhance and coordinate the transition of programs and services for children, youth and families. An advisory committee has been working closely with both ministries to ensure child and youth services are child-centred, and promote healthy development.

In order to reform mental health services, it is also necessary to implement quality practices to create a cultural shift. The Ministry of Health Services has released the Guidelines for Elderly Mental Health, and work is underway to develop a Provincial Anxiety Disorders Strategy Report, a Provincial Depression Strategy, and a Mentally Disordered Offenders Handbook. The ministry is also establishing best practices guidelines in several areas of mental health care, including the following: Support for Families With Parental Mental Illness; Mental Health Patient Rights; and Mental Health Care for Women.

Our government is committed to working with all British Columbians to improve the lives of those with a mental illness.

Honourable Gulzar Cheema
Minister of State for Mental Health

MESSAGE FROM THE MINISTER OF STATE FOR INTERMEDIATE, LONG TERM AND HOME CARE

Our government is committed to high quality, patient-centred care and achieving this goal will require significant changes at all levels of B.C.'s health system. Premier Gordon Campbell created my position of Minister of State for Intermediate, Long Term and Home Care to help fulfill our government's commitment to provide British Columbians with the level of care they need, when they need it and where they live.

Those of us with responsibility for home and community care services know that we must increase the capacity of communities to enable people to live independently. As well, we must ensure appropriate residential care for those with more complex needs.

We also know that seniors – those people over 65 years old – currently make up about 13 per cent of the provincial population. In the next 25 years, they will represent 21 per cent of the population.

Not only is the number of elderly growing, but our seniors and people with disabilities are generally healthier, more educated and lead more active lives. They want options in the type of care they receive and where they receive it. They are looking to government to provide a broader range of options than are currently available – options that will promote independence, choice and quality of life.

The challenge we face is to meet the needs of British Columbians in a sustainable way.

At present, there are gaps in the continuum of home and community care – gaps that prevent independent living. As part of our New Era commitments, our government has taken steps to bridge some of the existing gaps in the continuum of care. We have made a commitment to expand home care and palliative care services to assist chronically and terminally ill patients with supportive home environments, as an option to institutional care.

We have also committed to work with the private and not-for-profit sector to build and operate an additional 5,000 new intermediate and long-term beds for our aging population by 2006. In 2002, we took the first step by announcing 3,500 new supportive living units to be introduced over the next three years.

To meet these commitments, the Ministry of Health Services is finalizing a Home and Community Care Strategy that will significantly transform Home and Community Care over the coming years.

We must shift away from more costly and less than ideal institutional solutions to care that is more appropriately delivered in people's homes and communities. That is the premise for our new home and community care strategy.

We have engaged an expert panel to develop a discussion paper on end of life care for consultation, leading to a provincial

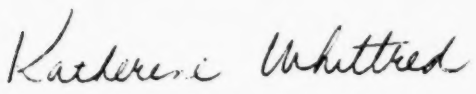
strategy. The strategy will examine how the range of home and community care services can better serve terminally ill British Columbians.

The recently implemented Palliative Care Benefits Program supports people living at home with an end-stage illness by providing medication for pain and symptom relief, and medical supplies and equipment, at no charge.

These measures bridge some of the gaps on one end of the spectrum of home and community care services. But there are more areas along the continuum of care that need work.

We made a commitment to develop an Intermediate and Long Term Care Facilities Plan that will address the needs of our aging population and free up existing acute care beds.

The steps we take over the next few years in government, and in both the non-profit and private sectors, will ensure British Columbians will have access to the support and health care options that meet their unique needs.



Honourable Katherine Whittred
Minister of State for Intermediate, Long Term and Home Care

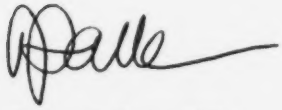
MESSAGE FROM THE DEPUTY MINISTER

I am pleased to present the 2001/02 Annual Report of the Ministry of Health Services. The past fiscal year has been a year of transition – and a year of facing challenges, developing innovative solutions, and creating a new vision for B.C.'s health care system. Our health care system faces challenges on a number of fronts, and these are not unique to British Columbia. These include addressing critical skills shortages and staffing levels of health professionals, cost pressures on our health care system, and the increasing demand for health services due to a growing and ageing population. These challenges are being felt in communities and provinces across Canada.

To address these challenges, the former Ministry of Health was reorganized, and a new ministry focusing on health planning was created. The Ministry of Health Planning and the Ministry of Health Services are now working closely on innovative ways to build a sustainable health system for the future. The number of health authorities has been reduced, from 52 to six, to achieve greater efficiency so resources can be redirected to patients. These newly created health authorities have now established three-year health service plans to reform and renew patient services for each region. As well, performance agreements have been established to ensure health authorities are accountable for fulfilling their duties and providing patient care that meets British Columbians' needs. This fundamental restructuring has allowed the creation of organizational structures, which enable us to work closely together with the health authorities to plan the much needed change in our health care system.

As you will see from this report, along with these significant structural changes, there has been an enormous amount of work done and goals accomplished during this year of transition. Our achievements have been focused on the need to ensure all citizens in every part of the province have access to high quality health services across the continuum of care. In addition, we are building a comprehensive culture of accountability for the work we do in government and the work done by our colleagues in the health sector.

Our achievements are due in a large part to the dedication, commitment, and extraordinary contributions of our staff, health authorities and health care partners. Our progress to date has already positioned us to better meet the needs of our citizens in the area of health care.



Penny Ballem, MD
Deputy Minister

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YEAR-AT-A-GLANCE HIGHLIGHTS

SETTING THE CONTEXT FOR CHANGE

2001/02 was a year that signalled the beginning of a new era in the management of B.C.'s public health care system. The stage was set for sweeping changes required to renew the system, and to help British Columbians in their efforts to maintain and improve their health.

Those changes are affecting the way services are delivered in a very real way. It is important for British Columbians to understand reasons for the changes they see taking place in their communities.

In the recent past, our health system has been under constant pressure to treat more people, expand services and increase wages to service providers. New technology, drugs and surgical procedures bring the promise of better health outcomes and fuel increased public demand for services. The government provided more than $1 billion in new funding to the provincial health budget in 2001/02, and yet, there seems to be unlimited demand for more.

British Columbians are asking, "if we're having trouble meeting demands now, how will we afford health care in the future?"

In fact, the problems we face today are not new, and British Columbia is not alone in this struggle. In 2001, the federal government announced a national commission on the future of health care in Canada, headed by Roy Romanow. The commission will make recommendations on how to sustain a publicly funded health system that balances investments in prevention and health maintenance with those directed to care and treatment.

The Romanow Commission is not the first of its kind. Governments have been searching for solutions through a series of health care reviews including: Alberta's Mazankowski Commission, Saskatchewan's Fyke Commission, Quebec's Clair Commission and the federal Kirby Commission.

In British Columbia in 2001, two comprehensive provincial reviews were undertaken, which helped provide the framework for change. The first of these, the Fiscal Review, examined the province's finances. The second, called the Core Services Review, examined all government programs and services.

Throughout the year, consultations on the health system were held. The Premier's Dialogue on Health was a forum which brought together 140 health care professionals, administrators, patients, community leaders, union representatives, other experts from across British Columbia and Canada, and members of Cabinet, to identify solutions for saving and renewing public health care and protecting patient care. The Legislative Assembly Select Standing Committee on Health received 700 submissions and held hearings around the province to involve the public in the discussion.

These reviews and consultations confirmed that B.C.'s health care system is facing a wide array of challenges to its long-term sustainability. Three key issues were identified: growing demands on publicly funded services, structural barriers which impact patient care, and a need for better planning and stronger accountability to patients and taxpayers.

Demands on B.C.'s Publicly Funded Services

British Columbians are among the healthiest people in the world, with relatively high life expectancies – 76.5 years for men and 81.4 years for women. However, as our population ages and grows, it uses health services at increasingly higher rates.

The 'demand' drivers for health services are:

- Population growth
- An aging population
- New technology and drugs
- The patterns of disease

Generally, annual population growth in B.C. is in the range of one per cent, however growth in the 80 - to 85 year age group has exceeded six per cent in recent years. Changing demographics will continue to have significant implications for the system, particularly as our baby boomers age.

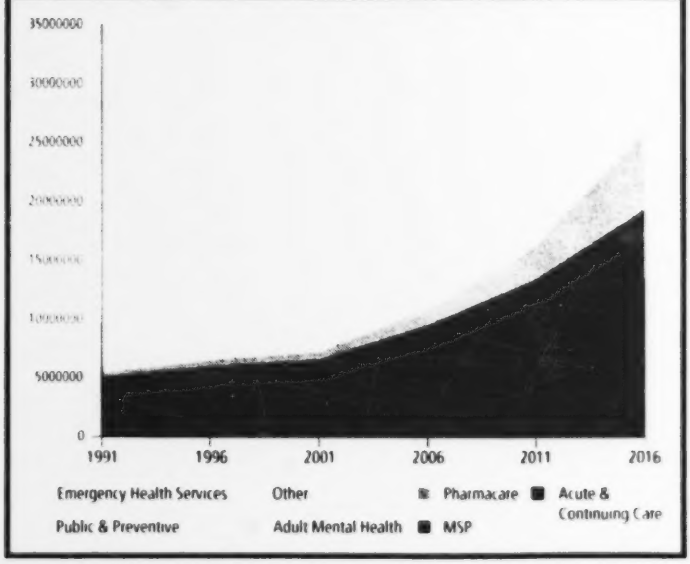
Public expectations are also rising, along with the availability of new technologies and advancements in medical procedures. In many cases, those new technologies allow more services to be delivered safely to more patients. For example, the coronary by- pass surgery rate for seniors has risen 51 per cent in the last 10 years, in part because improvements in this type of surgery have allowed a wider range of patients to benefit from it. New developments in treatments, drugs and diagnostic procedures are typically expensive, and are hitting the market with increasing regularity. The budget for cancer drugs has increased by almost 250 per cent in the last six years. The challenge is to ensure the public system makes the best use of technology, based on patient need and the best evidence about the impact of the technology on patient outcomes.

B.C.'s health care professionals and support workers are among the highest paid in the country. The worldwide shortages of health care professionals will continue to exert pressure on the system. Labour accounts for approximately 80 per cent of health care costs for services delivered in hospitals and through community programs.

Health care costs in B.C. have been growing three times faster than the growth rate of the economy. Pharmacare costs have been rising at a rate of roughly 15 per cent per year in recent years.

The graph shows where the province's health care costs would have been headed without change. B.C.'s health care system, if left to expand according to historical experience and demographic trends, would

B.C. MINISTRY OF HEALTH ACTUAL & PROJECTED EXPENDITURES BY PROGRAM, IN YEAR 2001



have increased at a rate of approximately 6.5 per cent per year.

Structural Barriers

A number of structural barriers must be eliminated and business arrangements improved to support high quality, sustainable patient care.

Emergency wards in acute care hospitals are the safety net for the system but are frequently used where less expensive care could be provided. Services delivered through hospitals are among the most expensive in the system, and are not always the most appropriate care for patients. Prevention initiatives and alternative community services such as hospice have traditionally had difficulty competing with demand for immediate cures. This means missed opportunities for breaking the cycle of over-reliance on hospital care.

Health care professionals require improved access to **patient information** as patients move through different parts of the system. Poor information can lead to gaps, duplication and variation in quality of services provided.

As well, **traditional methods of compensation** may not encourage the most effective system of care. For example, the fee-for-service system for physicians emphasizes the volume of services rather than continuity of care. The ministries are working with physicians to identify better alternatives.

Health authorities provide many of the services British Columbians think of when considering health care: acute care, residential care, mental health and public health services. Previously, 52 independent health authorities provided those services to British Columbians. The result was a cumbersome and inflexible system, difficult to manage, with overlapping responsibilities and minimal accountability to the public. Many regions were simply too small, lacking a sufficient population base to provide a broad range of quality services.

In addition to these structural barriers, **federal contributions** to health spending in B.C. fell significantly behind the increased costs of health care borne by the province.

Need for Better Planning and Accountability

At the provincial level, there was insufficient focus on the critical functions of long-term strategic human resource planning and long-term planning for capital facilities and information technology needs. There was too much emphasis on dollars spent and too little attention paid to whether particular expenditures improved patient care. As well, the accountability relationship between health authorities and government was weak.

Recognizing the problems in such a large and complex system was an important first step towards improving it. The next step was to plan new approaches and start implementing them. The following sections highlight the changes and accomplishments of the past year.

RENEWING HEALTH CARE—A YEAR OF CHANGE

New Roles and Mandates

One of the first tasks to achieve change was to restructure the system—to build a framework to guide and support the envisioned renewal and sustainability of the system.

In June 2001, the former Ministry of Health and Ministry Responsible for Seniors was restructured into two ministries—the Ministry of Health Planning and the Ministry of Health Services—to reflect the priority government places on a planned and accountable system. While both ministries provide overall leadership and direction for the health system, the Ministry of Health Planning was created specifically to address long-term planning for health services.

The Ministry of Health Services is responsible for implementing performance expectations and monitoring results for health authorities, and planning and administering the Medical Services Plan, Pharmacare and the Ambulance Service.

In December 2001, health authorities were reduced from 52 to six, setting the stage for a consolidation of services and the establishment of provincial accountability mechanisms. This includes service standards and performance agreements to be implemented in the 2002/03 fiscal year.

The breakdown of the ministries' and health authorities' mandates and functions is as follows:

Ministry of Health Planning

Mandate to develop and articulate expectations of health system performance and monitor the health of British Columbians.

Functions:

- Report on population health and respond
- Plan
- Develop legislation, policy, standards and other performance management tools

Ministry of Health Services

Mandate to fund, monitor and evaluate health system performance against clearly stated expectations.

Functions:

- Fund and direct health authorities
- Monitor and evaluate health authority performance and respond
- Operate Pharmacare and Medical Services Plan (MSP)
- Provide emergency services (B.C. Ambulance Service)

Health Authorities

Mandate to effectively and efficiently manage and deliver a range of health services, including acute and hospital care, home and community care, mental health, addictions and public health services.

Functions:

- Deliver and manage patient services
- Develop and report on patient and management outcomes
- Facilitate community input

MINISTRY RESTRUCTURING – REFOCUSING ON PRIORITIES

In January 2002, the Ministry of Health Planning and the Ministry of Health Services announced further structural changes to enable the ministries to refocus on setting overall policy and direction and monitoring performance.

The health planning ministry was created to provide a stronger focus on, and sustained effort toward, long-term planning for health services. There are three divisions under the new ministry structure. The Strategic Change Initiatives Division oversees specific projects designed to improve service quality, access and efficiency—for example, specific primary care projects planned for implementation in 2002/03. The Planning, Policy and Legislation Division works with health care partners in developing long-term plans, standards and a broad accountability framework for the health system. Responsibility for the health and wellness function was realigned with the Office of the Provincial Health Officer and transferred to the Ministry of Health Planning to renew efforts for developing strategies for disease prevention.

The health services ministry was restructured to align its organization with its new mandate, and established review and planning processes for devolving most remaining direct care services to health authorities. For example, Addictions Services will be transferred to the health authorities in 2002/03. The many divisions and programs in the ministry were reconfigured to support core business functions. Some offices were consolidated and some lower priority services were discontinued. The operational functions of Pharmacare and the Medical Services Plan were transferred to the Corporate Services and Financial Accountability Division, while the policy responsibilities were transferred to the newly created Medical and Pharmaceutical Services Division.

These decisions are consistent with the provincial government's priority to target spending on maintaining the delivery of direct patient services. Overall, these strategic shifts will result in reductions of more than 40 per cent in some corporate and program management budgets for both health ministries. The associated savings will help fund patient care.

Health Authority Restructuring—Focusing on Patient Care

As part of its strategic planning role, the Ministry of Health Planning took on the difficult task of restructuring health authorities. The previous regional governance structure was the most complex in Canada. With 52 health authorities, it was difficult to manage and had lost its focus on patient care.

The large number of separate health regions set up artificial barriers. For example, Kelowna and Vernon share many resources such as an airport, university-college, TV station and even a phone book. But they did not share a health region, even though hundreds of people from Vernon are treated at Kelowna General Hospital.

To make operations more efficient and accountable to patients and government, 15 health service delivery areas were established to reflect natural patient referral patterns. Five governing authorities—responsible for planning and co-ordinating services across the 15 health delivery areas—were created. Dividing the province into five geographic health authorities provides enough of a population base and budget in each to offer a full range of services, and provides opportunities for economies of scale.

The ministry also established a Provincial Health Services Authority. This authority coordinates and delivers highly specialized services that can't be offered in all regions. It is also responsible for facilitating coordination of provincial initiatives, which will improve access to care.

Changing the structure is only the first step. The ministry has also changed how health authorities are funded. Instead of funding for one year, health authorities receive

three-year budgets so they can plan ahead. A new population-based funding model was also developed in 2001/02 for implementation in 2002/03. The model takes into account the characteristics of the regions' population and its associated health needs, with the aim of ensuring fairness and transparency.

In March 2002, the health planning minister announced the new community members of the Health Authority Boards. Members were chosen for their leadership skills, decision-making abilities and willingness to be accountable through performance agreements.

The final result is a new structure that is simplified, functional and highly accountable to patients and British Columbians.

New Structure for B.C.'s Health Care System

Leadership Council—Coordinating New Relationships

A Leadership Council was established, with representation from the Chief Executive Officers in health authorities and senior representatives from the health ministries. The council is chaired by the Deputy Minister and provides input on establishing strategies, direction and accountability frameworks.

Bill 29—A Major Tool for Change

In January 2002, the government introduced the Health and Social Services Delivery Improvement Act (Bill 29). The Act ensures health authorities have the flexibility to make decisions about services and staff in the best interest of patient care.

RENEWING HEALTH CARE–A YEAR OF CHANGE

National and Provincial Studies on Health Care Issues
(Seaton, Fyke, Clair, Mazankowski, Kirby, Romonow)

REVIEW IN BC

BC GOVERNMENT FISCAL REVIEW
(Comprehensive review of finances)

Premier's Dialogue on Health in Vancouver with professionals

BC Legislative Assembly Select Standing Committee consultations with public

CORE SERVICES REVIEW
(Comprehensive review of all ministry programs and services)

RESTRUCTURING

Creation of Health Planning and Health Services ministries (one to focus on planning; the other on management of operations)

Leadership Council to ensure common strategic approach

Streamlined Regional Health Authorities to focus resources on patient care

PLANNING & REPORTING

Ministry Service Plans with goals, strategies and clear performance measures and targets

Health Authority Performance Contracts to detail patient and management outcomes

Annual Service Plan Reports prepared by both ministries and health authorities showing their performance results

MINISTRY ROLE AND SERVICES

Vision

A health system that ensures high quality public health care services that meet patients' needs where they live and when they need them

WHAT IS THE ROLE OF THE MINISTRY OF HEALTH SERVICES?

The Ministry of Health Services provides funding, direction and leadership to regional health authorities in support of the delivery of quality health care services throughout the province. In turn, the health authorities run the system's day-to-day operations. The ministry works with the authorities to develop three-year budgets and provide annual funding. The ministry also implements performance agreements with the health authorities that outline clear objectives for the health care system. To allow for continuous improvements, the ministry monitors results and reports back to the health authorities, government and all British Columbians.

Mandate

The Ministry of Health Services funds, monitors and evaluates health service delivery and health system performance.

The ministry provides operational support to the Ministry of Health Planning. It also operates the Pharmacare program and the Medical Services Plan to ensure British Columbians get the physician services and pharmaceuticals they need.

Pre-hospital emergency services, in every community of the province, are provided by the ministry through BC Ambulance Service.

Through innovation and change, the ministry is working with health care partners to develop solutions to address challenges facing our health care system today. These changes will help us realize our vision for a high quality public health care system that meets patients' needs.

Mission

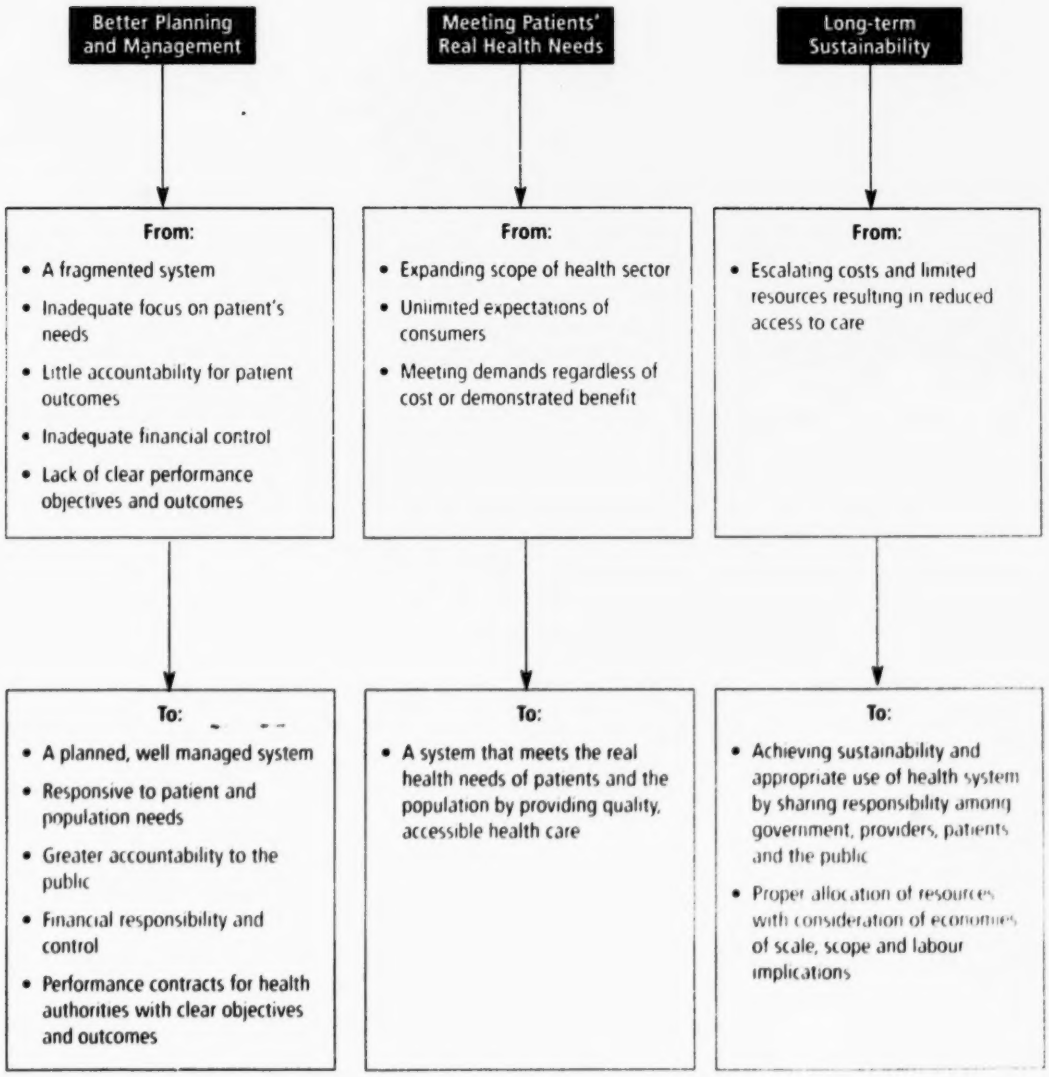
To guide and enhance the province's health services in order to ensure British Columbians are supported in their efforts to maintain and improve their health

The priorities of both the Ministry of Health Planning and the Ministry of Health Services are to fulfill the government's New Era vision of saving and renewing public health care and providing high quality health services that meet patients' most essential needs.

STRATEGIC SHIFTS

As a result of the Core Review process, the provincial government has undertaken three major strategic shifts to ensure high quality patient-centred care, to build a sustainable public health care system, and to enhance the health and wellness of British Columbians.

WHAT ARE THE STRATEGIC SHIFTS?


Better Planning and Management
From:
• A fragmented system
• Inadequate focus on patient's needs
• Little accountability for patient outcomes
• Inadequate financial control
• Lack of clear performance objectives and outcomes
To:
• A planned, well managed system
• Responsive to patient and population needs
• Greater accountability to the public
• Financial responsibility and control
• Performance contracts for health authorities with clear objectives and outcomes
Meeting Patients' Real Health Needs
From:
• Expanding scope of health sector
• Unlimited expectations of consumers
• Meeting demands regardless of cost or demonstrated benefit
To:
• A system that meets the real health needs of patients and the population by providing quality, accessible health care
Long-term Sustainability
From:
• Escalating costs and limited resources resulting in reduced access to care
To:
• Achieving sustainability and appropriate use of health system by sharing responsibility among government, providers, patients and the public
• Proper allocation of resources with consideration of economies of scale, scope and labour implications

MINISTRY CORE BUSINESS

The Ministry of Health Services has four core business areas: Performance Management and Improvement Division; Emergency Health Services; Medical and Pharmaceutical Services; and Corporate Services and Financial Accountability. This section briefly describes the function of each and highlights major events and changes for 2001/02.

1. Performance Management and Improvement Division:

Health authorities are responsible for the direct delivery of many health services in B.C., including acute care services, residential and community care, mental health and public health services. The Performance Management and Improvement Division is the main link between the province and the health authorities. It works with health authorities, service providers and other industry stakeholders to implement clear performance standards and effective monitoring systems. This division also works closely with the Corporate Services and Financial Accountability Division, which is responsible for managing the financial performance of health authorities. The ministry provides three-year funding allocations according to these performance and accountability standards.

Values

Patient and Consumer Focus

Equity

Access

Effectiveness

Efficiency

Appropriateness

Safety

These values reflect our commitment to the five principles of the *Canada Health Act*: public administration, comprehensiveness, universality, portability, and accessibility.

Performance Agreements

What are they?

For the first time ever, health authorities will sign performance agreements that will hold them accountable for the delivery of patient care, patient outcomes and how health dollars are spent.

Performance agreements between health authorities and the ministry define expectations and performance deliverables for three fiscal years. The agreements also contain major change requirements in areas of service such as emergency care, surgical services, home and community care, and mental health.

What are we doing?

The ministry is putting in place contracts to ensure accountability—these are performance agreements. Performance agreements, introduced in February 2002, enhance accountability of health authorities for services delivered. Government is holding health authorities across B.C. accountable for dollars spent and the effectiveness of health service delivery.

It's a change from measuring the performance of our health system by how much money is spent to measuring the effectiveness of patient outcomes.

The ministry has established monitoring processes incorporating the regular review of health authorities' reporting and performance. The ministry and health authorities will also be working together more closely to evaluate health system performance. Under the performance agreements, it is required that Health Authority Board Chairs establish a performance-based component of compensation for senior management.

What does this mean to you?

New performance contracts will allow government and health authorities to determine how health dollars are spent and how effective our health care system is in meeting patients' needs. These agreements will improve accountability and help us build a more sustainable, effective health care system in B.C.

Changes in structure, programs and services

- To make operations more efficient and accountable to British Columbians, the regional health authorities were reduced from 52 to six. There are now five geographic authorities that are responsible for managing services across 15 health service delivery areas, and one provincial health services authority. The provincial authority is responsible for coordinating the delivery of provincial programs and highly specialized health services.

- The streamlining of regional authorities enables consolidation and reduction of corporate infrastructure across health regions, a process which began in 2001/02.

- Similarly, in support of maintaining higher priority services, health services are being consolidated within and across regions.

- The ministry introduced performance agreements with health authorities. The agreements, which will be implemented next year, specify expectations and accountabilities to ensure the public obtains good value, quality services and improved health outcomes from the health system. The ministry also gave the regions the authority to change how and where services will be provided so that they can meet performance expectations, in an effort to create a sustainable quality health care system. (See the topic box on performance agreements on page 11.)

- The ministry introduced a new population needs based funding method, which allocates available funding to health authorities according to their populations' relative health care needs. (See the topic box on population needs based funding.)

Population-Based Funding Formula

What is it?

Population-needs based funding is a method of allocating available funding to health authorities according to their populations' relative health care needs. Many countries are moving towards population-needs based funding for health care, to ensure that the allocation of funds is fair, equitable, accountable and transparent to all.

What are we doing?

The ministry implemented population needs based funding to allocate funds to health authorities for acute care and home and community services for 2002/2003.

Population-needs based funding first looks at the average use of health care services across the province by age, gender, and socio-economic status, and then estimates health care services the population would need.

The populations of the five health authorities are unique. For example, Vancouver Island's population is older, while the Lower Mainland has a higher proportion of people in lower income groups. Age and socio-economic status are important determinants of health and the need for health care.

Since people can go to hospitals in other regions for treatment, funding adjustments are also made for health services, based on the pattern of inter-regional flow.

Finally, the model is adjusted for the relative cost of delivering health care in different regions. A remoteness factor for small scale populations and a complexity factor for higher costs in B.C.'s largest hospitals are included in the determinants of funding.

The Ministry intends to develop funding allocation models for mental health and preventive and public health in the future, modelled on the same principles.

What does it mean to you?

Regardless of where you live in the province, British Columbians will have access to high quality, patient-centred care. It all starts with a fair and equitable distribution of funding to health authorities based on population needs.

- Government introduced the *Health and Social Services Delivery Improvement Act*, which enables health authorities to introduce new, cost-effective business arrangements to incorporate alternate service delivery methods and public/private partnerships in the provision of services.

- The ministry is developing a Home and Community Care Plan and implementing the Mental Health Plan to optimize the use and efficiency of residential care services and home and community based services. Implementation will be phased in over the next several years.

2. Emergency Health Services

The British Columbia Ambulance Service (BCAS) provides pre-hospital emergency care, including air and land emergency transport.

Changes in structure, programs and services

- Strategies were developed to reduce demand for services by redirecting low priority calls to other resources, such as the BC Health Guide NurseLine and Poison Control. This will ensure optimal use of specialized skills and resources.

- Emergency health services are being examined under the core review process, with recommendations to be released in 2002/03.

3. Medical and Pharmaceutical Services

The Medical and Pharmaceutical Services division is responsible for setting policy for the Medical Services Plan (MSP) and Pharmacare program.

MSP is the medical insurance plan for residents of British Columbia. It pays for medically required services provided by physicians, diagnostic and laboratory services, in-hospital dental services and some supplementary benefits. (See also topic box on MSP Accountability Activities.)

Medical Services Plan (MSP) Accountability Activities

What is it?

Activities are conducted by the Ministry of Health Services to ensure that all physician billings submitted for payment are legitimate. These audit activities are fully supported by the British Columbia Medical Association, the professional organization which represents physicians in this province. The Ministry of Health has been auditing practitioner billings since the 1970s.

What are we doing?

One such audit activity is the Service Verification Survey, whereby approximately 6,250 members of the public are randomly selected each month and are asked to confirm that they have received the services billed to MSP in their names. MSP also has a number of other safeguards in place to monitor the billing patterns of practitioners, including a Billing Integrity Program (BIP), which is responsible for detecting and deterring inappropriate billing. BIP produces annual statistical profiles for each physician in the province. Statistically unusual patterns of billing are subjected to review based on criteria that are agreed to by the Patterns of Practice Committee (comprising both government and medical profession members) and, where necessary, subsequent investigation. Similarly, tips and complaints received from public sources are reviewed by MSP for possible irregularities.

What does this mean to you?

The services of practitioners are regularly monitored and audited to ensure accountability and validity of payments for patient care.

Changes in structure, programs and services (MSP)

- Effective January 1, 2002, the ministry changed coverage of supplementary benefits under the Medical Services Plan to focus on assisting those in greatest need. Physiotherapy, chiropractic, massage therapy, naturopathy, and non-surgical podiatry coverage is now provided only for those receiving premium assistance to a maximum of 10 visits annually for the combined range of services. Surgical podiatry is insured for all beneficiaries.

- Coverage for routine eye exams was eliminated for adults (19 to 64 years), beginning November 2001. Coverage for routine eye exams will continue for individuals under 19 and for seniors, the two groups who receive the most value from this health service. All medically necessary eye exams will continue to be covered.

- Enhanced physician compensation arrangements are being implemented in the spring and summer of 2002, following finalization of agreements with the BC Medical Association.

Pharmacare, the province's public drug insurance program, assists British Columbia residents in paying for eligible prescription drugs and designated medical devices and supplies. The program administers benefits through various plans. The largest are those for seniors, people receiving income assistance and the public. (See the topic box on Pharmacare Plan Changes.)

Changes in structure, programs and services (Pharmacare)

- In the face of rapidly growing Pharmacare costs, the ministry is moving to income testing for 2003, and made interim changes for 2002 to manage expenditures. Changes in deductibles effective January 2002 include the following.

Pharmacare Plan Changes

What is it?

Effective January 1, 2002, the government introduced changes to Pharmacare plans. These changes are being made in response to escalating costs and the need to protect the future viability of the Pharmacare program.

What are we doing?

Pharmacare policy changes affected Plan A (seniors) and Plan E (universal) beneficiaries. The government introduced these changes to address immediate cost pressures while preserving access to benefits for those who can least afford paying for these services.

When the ministry made these changes, care was taken to protect low-income seniors, the 40 per cent of seniors who qualify for premium assistance.

The Pharmacare changes are an interim step for 2002, while the ministry works to introduce a new income-based Pharmacare program in January 2003. Pharmacare is continuing to monitor the impact that this policy change is having on drug utilization rates and expenditures in B.C.

What does it mean to you?

Pharmacare costs have been increasing by an average of 15 per cent annually in recent years. Continuing with the same program was unsustainable. These benefit changes mean higher deductibles, while offering some protection to those British Columbians who require assistance from benefit cost changes.

A redesign of the Pharmacare plans will ensure that health consumers requiring pharmaceuticals will be assisted with the costs of treatment in a viable manner. A new, restructured Pharmacare program will share the high costs of drugs between public and private sources, ensuring that Pharmacare is sustainable.

- The annual deductible for seniors is based on both the ingredient cost and the dispensing fee. Seniors with higher incomes pay up to a maximum annual deductible of $275 with a limit of $25 per prescription. The maximum annual deductible for the 40 per cent of seniors who qualify for premium assistance

remains at $200 with a limit of $10 per prescription.

- Annual deductibles for B.C. families covered under Pharmacare's universal plan have increased by $200 to $1,000. Pharmacare covers 70 per cent of eligible costs between $1,000 and $2,000 per family, and 100 per cent of eligible costs over $2,000. For universal beneficiaries receiving MSP premium assistance, their annual deductible is $800, and Pharmacare covers 100 per cent of eligible costs over that amount.

- In 2001/02, the ministry began planning for income-testing for Pharmacare benefits.

4. Corporate Services and Financial Accountability (CSFA)

This division provides corporate support services for both health ministries, including financial, information management, human resources, client services and Freedom of Information and Protection of Privacy functions. Working in conjunction with the Performance Management Improvement Division, Corporate Services and Financial Accountability (CSFA) establishes financial performance standards and monitoring systems for all six health authorities. It also provides for financing for capital health projects, such as new long-term care facilities and medical equipment and machinery. (See Report on Resources on page 59 for a list of capital projects.) The Information Management Group of CSFA provides all information technology and information management services for the two ministries of health. This includes managing major projects which will use technology to improve health care delivery such as the Electronic Health Record (see topic box on the Electronic Health Record (EHS) Strategy) and Telemedicine (see topic box on Telemedicine and Telehealth on page 16).

Electronic Health Record (EHR) Strategy

What is it?

The Electronic Health Record (EHR) project will deliver and integrate your health information into a secure, accessible record. This means that health care providers will be able to obtain and share information electronically to make faster and better decisions.

What are we doing?

EHR is not one project but an evolution of a series of building block projects. Currently in use or under development are initiatives to tie laboratory, diagnostic images, pharmacy, hospital and health information from doctor's offices together for a complete picture of your health.

What does this mean to you?

Fulfillment of the EHR will result in the following kinds of improvements:

- *You and your health care providers will be able to get access to your medical information as easily and securely as you now get your banking information.*
- *Only you and the health care provider you authorize will have access to your personal health information.*

Changes in structure, programs and services

- The ministry established a revised capital budgeting process with health authorities, which sets the framework for 2002/03 and beyond. (see Report on Resources on page 59 for more on capital projects.)

- Funding was committed for capital projects that are part of the government's New Era commitments. All other projects, including those in planning stages, are being reviewed by the new health authorities to determine their priority among other local needs.

- Some limited one-time capital funding has been committed to assist health authorities in converting existing facilities to more appropriate uses consistent with new priorities.

- Opportunities to partner with non-profit organizations and the private sector are being explored.

5. Other changes in structure, programs and services across the ministry

- To ensure adequate resources for core health services, the ministry has streamlined or eliminated various ministry branches and special offices.

- These strategic changes will result in significant reductions in administration over three years with savings redirected to program delivery.

- The Population Health and Wellness function has been realigned with the Office of the Provincial Health Officer in the Ministry of Health Planning.

- Most remaining areas providing direct service are being transferred to health authorities. These include addiction services, aboriginal health contracts, the provision of clinical advice services for individuals with developmental disabilities and others.

- The ministry has eliminated advisory committees for health issues related to women, seniors and HIV/AIDs. Special advisors on the health of women, seniors and Aboriginal people have been consolidated in the Ministry of Health Planning.

- In the restructuring process, the BC Hearing Aid Program and technical support unit were discontinued. These services are available through the private sector. The Victoria and Burnaby MSP in-person client service offices have been replaced by telephone or Internet access.

Telemedicine and Telehealth

What is it?

Telemedicine uses state-of-the-art technology to connect patients, health professionals, specialists and researchers. Throughout our province, the possibilities for Telemedicine are endless. It could involve linking a physician's desktop to medical labs and hospitals. It could be a videoconference between a northern B.C. emergency room doctor at the bedside of a patient seeking advice from a Vancouver specialist.

What are we doing?

In February we announced the BC Telehealth program. This program includes an emergency/trauma program that connects Terrace and Cranbrook with larger care centres on a 24/7 basis. By the end of 2002, telehealth services will be available to many more communities in B.C.

Another initiative is the BCbedline. Physicians were spending hours trying to find a bed for some patients. This innovative service, BCbedline, has a Web site registry and a 24-hour call center. Thousands of calls have been made to the Bed Line and it makes a significant difference in reducing the time it takes to find beds for patients and in providing better care.

These are just two examples of Telemedicine projects now underway in B.C. High-speed networks, wireless technology, and sophisticated medical equipment all help provide health professionals and patients with more information, more effectively.

What does it mean to you?

It means when we are patients, we can more often be cared for in our community. It means as patients we can get more information, more quickly. And it means patients can access specialized care where they live, when they need it.

Most importantly, Telemedicine puts patients at the centre of care. It gives British Columbians better access and more care options to better meet our health care needs.

A HEIGHTENED COMMITMENT TO MENTAL HEALTH AND HOME AND COMMUNITY CARE

As part of last year's restructuring, the government created two separate Ministers of State - one for Intermediate, Long Term and Home Care, and another for Mental Health. These two appointments were made in recognition of the importance of these health care areas and the special attention that will be focused on them. Although the ministers fall under the responsibility of the Ministry of Health Services, they act as cross-government advocates for people who require these services. This includes making presentations to Cabinet and other government committees on their behalf. The following sections highlight the major initiatives in these areas.

HOME and COMMUNITY CARE

- The Minister of State for Intermediate, Long Term and Home Care is leading development of a new strategy to optimize the health of people with functional impairment due to aging, illness, or disability. The intent is to make available to a greater number of people services that are more responsive in promoting independence, choice and quality of life and that are cost-effective. The plan will optimize use and efficiency of residential care, community and home-based services.

- As part of the strategy, the ministry is also working to establish 5,000 new intermediate and long-term care beds over the next five years. This strategy will provide a more complete continuum of care for British Columbians, while reducing pressure on residential care facilities and hospitals.

Chronic Disease Care

What is it?

Chronic disease management strategies aim to help patients with chronic illnesses manage their condition, stay healthier, require fewer medical interventions, and ensure that medical interventions are timely and appropriate.

What are we doing?

With the Ministry of Health Planning, practitioners, interest groups, and pharmaceutical companies, we are developing clinical guidelines for health care professionals, implementing improvements in the care of diabetes and congestive heart failure, and recommending methods for patients to improve their own management of their illness.

In addition to diabetes and congestive heart failure, we will be addressing the care of asthma, chronic depression and anxiety disorders.

What does this mean to you?

Over time, we will see fewer acute care procedures in our hospitals for people with chronic conditions, such as diabetes. They will have the knowledge and services to manage their illness, and when they need medical intervention it will be provided based on what research shows works.

MENTAL HEALTH

- The Minister of State for Mental Health recently announced a $263-million action plan, over the next six years, to revitalize services, deliver better care and achieve better results for individuals with mental illness. The Mental Health Plan will encourage a cultural shift that moves from a system with little focus on patient involvement or outcomes to a one that is responsive to patient needs and accountable to the public.

UPDATE ON NEW ERA COMMITMENTS

On June 25, 2001, Premier Gordon Campbell sent a letter to each member of the Executive Council providing direction and outlining expectations. The Premier's letter to the Minister of Health Services itemized the New Era commitments and key projects for which the minister is accountable. Similarly, the Premier's letters to the Minister of State for Intermediate, Long Term and Home Care and the Minister of State for Mental Health also identified key projects for the ministers. The following is the list of New Era commitments and key projects. A detailed description of the ministry's actions and progress on these assignments is contained in the following pages.

NEW ERA PROMISES FOR HEALTH SERVICES

1. Provide expanded home care and palliative care services to assist chronically and terminally ill patients with supportive home environments as an option to institutional care.

2. With the Office of Chief Information Officer and Health Planning, build a unified, universal and cost-effective health services information network that will improve care and reduce costs.

3. With Finance and Management Services, increase technology funding and digital infrastructure support to facilitate telehealth options that will expedite and improve treatments and reduce travel requirements for Northern and rural residents.

4. Ensure that patients living at home in palliative or long-term care are entitled to the same pharmaceutical benefits as they would have if they were in a hospital.

5. Intensify efforts to promote wellness and preventative care through better education, dietary habits and physical activity.

6. Provide better home support and home care services.

7. With the Ministry for Children and Family Development, increase emphasis on early childhood intervention programs for families with special needs children.

8. With Health Planning:

   a. Give all citizens better access to their medical records and treatment histories, and enhanced information privacy rights.

   b. Support community services volunteers and repeal legislation that allowed government to expropriate community health facilities without compensation.

   c. Enhance preventative drug and alcohol efforts, such as addiction counseling for new mothers and the reduction of fetal alcohol syndrome.

   d. Work to minimize interjurisdictional overlaps that are adding confusion and costs to health care delivery.

e. Protect existing levels of access to abortion services throughout the province.

f. Increase locum support to relieve pressure and reduce workloads to enhance health care professionals' quality of life.

g. Work with non-profit societies to build and operate an additional 5,000 new intermediate and long term care beds by 2006.

h. Replace obsolete hospital and ambulance equipment and ensure all equipment is fully utilized and properly maintained.

9. Give ambulance attendants better access to training.

10. Fully fund and implement the $125 million mental health initiative.

11. Focus funding on patient care, by reducing waste in the system and eliminating administrative duplication and costs from provincial government mismanagement.

12. With Intergovernmental Relations Secretariat (IGR) and Finance, negotiate with the federal government to restore all of the health care funding withdrawn through budget cuts.

13. With the Ministry of Finance:

a. Fulfill B.C.'s obligations under the *Canada Health Act* to properly fund and provide access to all medically necessary services.

b. The Ministry of Health Services' budget was increased to $9.5 billion in 2001/02.

c. Provide health regions and hospitals with three-year rolling funding commitments (updated annually), to enable them to plan and act with certainty.

d. Fund health regions at a level necessary to meet the needs of the people who live there, regardless of where a service is provided.

Key Projects for Health Services

1. Implement a monitoring system and accountability model for Regional Health Boards.

2. Develop a response plan for non-performing organizations.

3. Prepare service plans for provincially delivered health services.

4. With Health Planning, develop an information management strategy, focusing on health information for the general population and on data standards for regional health authorities.

5. Cooperate with the Ministry of Children and Family Development on early childhood development initiatives.

Key Projects for the Minister of State for Intermediate, Long Term and Home Care

1. Within the current budget allocation, and in coordination with Health Planning, ensure early action on intermediate, long-term and home care services.

2. Serve as the point person for those wishing to make representation on issues related to continuing care.

3. Establish a new and cost-effective strategy to provide 5,000 new intermediate and long-term care beds over the next five years.

Key Projects for the Minister of State for Mental Health

1. Within the current budget allocation, and in coordination with Health Planning, ensure early action on mental health services.

2. Become the advocate for mental health services throughout government.

3. Establish a public information program on mental health issues and community services in cooperation with other government agencies, professional bodies and community groups.

NEW ERA PROMISES

1. **Provide expanded home care and palliative care services to assist chronically and terminally ill patients with supportive home environments as an option to institutional care.**

The ministry is developing a provincial strategy to optimize the health of persons with functional impairment due to aging, illness or disability. The intent is to expand and redesign the home and community care system to provide services to a greater number of people, be more flexible and responsive, and more cost-effective. The objectives are to improve the assessment process, streamline access to services, support clients to remain independent in their homes for as long as possible and develop affordable housing-based care options. The ministry has also begun work on a provincial strategy to improve the delivery of services at the end of life, and has implemented a program to provide home-based palliative clients with the same pharmaceutical benefits as they would have if they were in hospital.

2. **With the Office of Chief Information Officer and Health Planning, build a unified, universal and cost-effective health services information network that will improve care and reduce costs.**

The ministry is currently working with the Office of the Provincial Chief Information Officer (CIO) and the health authorities on strategies for accessing telecommunications networks with sufficient bandwidth. This is the key to successfully implementing telehealth and telemedicine, linking physicians' desktops to medical labs, pharmacies and hospitals, and making the Electronic Health Record (EHR) and other electronic service deliveries to the public on a province wide basis a reality.

The ministry is working with the Provincial CIO and health authorities to explore opportunities to use Optical Regional Advanced Network (ORAN), to link research institutions nationwide for health education, research and services purposes.

In addition, the ministry has conducted a Secure Information Transport Strategic Options Project (e-Secure) to provide practical options for secure information transport among the various health sector stakeholders. This is the necessary first step towards developing secure information transport solutions.

The ministry is also working with the Provincial CIO and the central IT agency (CITS) on the corporate portal project for delivering services over the Internet to the public and businesses.

3. **With Finance and Management Services, increase technology funding and digital infrastructure support to facilitate telehealth options that will expedite and improve treatments and reduce travel requirements for Northern and rural residents.**

The government has been working with the federal government through the Canadian Health Infostructure Partnership Program to facilitate telehealth options in the province. Four projects are currently underway, the largest of which is the BC Telehealth Program. Through this program, videoconferencing services are offered in the areas of emergency/trauma, continuing medical education, maternal and child, and pediatric palliative care. Five health authorities, UBC and several Child Development Centre providers across the province have joined together to implement the program. Specific communities benefiting from the program include: Prince Rupert, Terrace, Kitimat, Smithers, Prince George, Kelowna, Kamloops, Penticton, Cranbrook, Invermere, Fernie, Victoria and Vancouver.

The emergency/trauma component of the BC Telehealth Program began in February 2002. Emergency and trauma physicians at Vancouver General Hospital provide 24/7 trauma and emergency support to their physician colleagues in Terrace and Cranbrook. In its first month of operation, 17 seriously ill or injured patients were treated in their own communities through telehealth.

Other projects are also now underway in B.C. that demonstrate the many ways telehealth can benefit health care. High speed networks, wireless technology, and the increasing capabilities of computers and medical peripherals are all helping to provide health professionals with more information and the means to deliver health care services in a more effective manner. To facilitate telehealth and telemedicine implementation, the ministry is working with the Ministry of Management Services and the Provincial Chief Information Officer to address network bandwidth capacity issues.

4. **Ensure that patients living at home in palliative or long term care are entitled to the same pharmaceutical benefits as they would have if they were in a hospital.**

The ministry has implemented a program to provide home-based palliative clients with the same pharmaceutical benefits as they would have if they were in hospital. An evaluation of the program will be conducted in the near future to ensure the needs of clients are being met. In 2002, the ministry will also be developing a program to provide palliative clients in residential care facilities the same pharmaceutical benefits as they would have if they were living at home or in a hospital.

5. **Intensify efforts to promote wellness and preventative care through better education, dietary habits and physical activity.**

The ministry is working with health authorities to develop a Chronic Disease and Injury Prevention Strategy that focuses on five priorities: physical activity, healthy eating, tobacco reduction, alcohol and drug misuse, and preventable injury, especially falls among seniors. A draft discussion paper has been prepared to support and foster collaborative approaches to address the primary prevention of chronic disease and disability among British Columbians.

The ministry is working to engage other ministries, health authorities and non-government organizations in collaborative action to lower British Columbians' risk of chronic disease and disability. As an example, the ministry is collaborating with the Ministry of Community, Aboriginal, and Women's Services and others to develop a Sport and Physical Activity Policy for B.C. that targets actions in schools, communities, and elite sport.

6. Provide better home support and home care services.

New provincial standardized assessment tools for home care and residential care have been successfully tested and validated. These new tools provide a comprehensive assessment of client needs and will result in the right care being provided to the right client at the right time. They are a critical component of effective case management, planning, resource allocation and outcome measures. Health authorities are now implementing the new assessment tools with full implementation required for the home care tool by March 2005, and the residential tool by March 2007.

7. With the Ministry of Children and Family Development, increase emphasis on early childhood intervention programs for families with special needs children.

As part of a joint initiative with the Ministry of Children and Family Development, the ministry is working to provide improved access to assessment and diagnostic services for children with autism spectrum disorder. Assessment and diagnosis standards have been drafted and access to assessment and diagnosis services has been improved through the initiation of three assessment centers. In addition, a data collection system has been developed, and a coordinated service delivery system is expected to be implemented by the summer of 2002.

8a. Give all citizens better access to their medical records and treatment histories, and enhanced information privacy rights.

The Ministry of Health Services' and Ministry of Health Planning's Information and Privacy Branch provides advice and assistance to the public, the ministries and health authorities on patients' access rights to their records. The branch also works to ensure patient privacy is protected and enhanced through pamphlets, phone Help Line, Intranet Site and training programs. The ministries require a privacy impact assessment to be conducted on all information systems projects involving personal information. Privacy assessments are also undertaken on all on new ministry programs and legislation.

Establishing the Electronic Health Record (EHR) to improve patient care and clinical decision making with due attention to security and privacy protection is a health information priority. The Chief Information Officer (CIO) of the health ministries and the CIOs of the health authorities are exploring strategies and approaches for establishing the Electronic Health Record (EHR) in B.C.

In addition, one of the main goals in the ministries' draft Strategic Plan for Health Information Management in BC is to make health information electronically available to British Columbians to help them improve wellness, learn about illnesses, find appropriate health services, and become informed of the best options and treatment practices.

8b. Support community services volunteers and repeal legislation that allowed government to expropriate community health facilities without compensation.

In August 2001, government repealed the section of the *Health Authorities Act* that allowed the assets of community health facilities to be seized without compensation. This supports community service volunteers by encouraging non-profit societies and volunteers to play an integral role in the delivery of health care, particularly for the elderly, without fear of government targeting their work.

8c. Enhance preventative drug and alcohol efforts, such as addiction counseling for new mothers and the reduction of fetal alcohol syndrome.

An overall addictions framework is being developed that includes a provincial alcohol and drug prevention strategy. The prevention of fetal alcohol syndrome is a key component of the strategy. The ministry is linking with key partners in the development of the framework, including health authorities, Ministry of Children and Family Development, Ministry of Community, Aboriginal and Women's Services, ICBC, and the Liquor Distribution Board.

8d. Work to minimize interjurisdictional overlaps that are adding confusion and costs to health care delivery.

The ministry has implemented the new governance structure for health care in British Columbia that will result in better coordinated and planned health care delivery. In December 2001, government reduced the existing 52 regional health authorities to five regional health authorities and a Provincial Health Services Authority (PHSA) to oversee provincial programs. Having fewer, more accountable health authorities will minimize the duplication of administrative services that have added confusion and costs to health care delivery.

The new model is focused on achieving efficiencies, eliminating administrative duplications, and directing as much money as possible to high-quality patient care.

8e. With Community, Aboriginal and Women's Services Ministry, protect existing levels of access to abortion services throughout the province.

Access is being monitored to ensure existing levels of abortion services throughout the province.

8f. Increase locum support to relieve pressure and reduce workloads to enhance health care professionals' quality of life.

The ministry is pursuing a number of avenues to increase locum support, particularly for health professionals in rural or remote communities. The ministry has been working to enhance its Northern and Rural Locum Program (NRLP). The program assists general practitioners and family practitioners working in about 70 small B.C. communities to secure subsidized vacation relief by keeping a roster of physicians to provide locum support. In 2001/02 the program provided over 3,200 paid days of locum coverage, the most days ever in its history. A further expansion of the NRLP has been proposed by government as part of the negotiations with the British Columbia Medical Association.

The ministry has also been engaging new physicians and professional groups in an effort to increase locum support. NRLP staff have been active in recruiting new medical school graduates into the program to gain experience in rural or remote practice as locums. In addition, the ministry has been linking with professional organizations such as the Canadian Society of Rural Physicians to explore how BC can benefit from established programs like the Society's Continuing Medical Education/Locum program which innovatively addresses the educational and staffing challenges of rural health care.

8g. Work with non-profit societies to build and operate an additional 5,000 new intermediate and long term care beds by 2006.

This commitment forms part of the ministry's overall strategy for home and community care. The ministry has been working with BC Housing on a supportive living initiative which will allow low and modest income seniors and people with disabilities to access support services in a home setting. The initiative calls for 3,500 supportive living units across the province: 1,500 new units will be constructed, 1,000 existing units will be converted, and 1,000 rent supplements will be provided to enable seniors and people with disabilities to live in supportive living units. It is a significant first step in meeting the goal of 5,000 beds.

8h. Replace obsolete hospital and ambulance equipment and ensure all equipment is fully utilized and properly maintained.

In 2001/02, the B.C. Ambulance Service ensured that all operational ambulances, spare ambulances and supervisory vehicles were equipped with automatic cardiac defibrillation equipment. Major communications enhancements were completed as new computerized dispatch systems were installed in the Kamloops and Victoria Regional Dispatch Centres. State of the art call recording equipment was also installed in both of these centers and in Vancouver. In addition, a project was initiated to install upgraded mobile radios and dataheads in all ambulances. Improvements to the communications network of mountaintop repeater sites are also underway.

The ministry is working with the health authorities to assess medical machinery and hospital equipment needs. Capitol and operating funding of $63 million was

approved for health authorities to buy diagnostic equipment such as CT scanners, modern clinical equipment for operating rooms and labs, and new beds and lifts to prevent injuries to health care workers. The restructuring of the health authorities and the introduction of service plans and performance agreements give health authorities the ability and incentive to ensure appropriate utilization and maintenance of hospital equipment to meet the needs of patients and providers. In addition, to address a specific need, $15 million was provided to health authorities for beds and lifts to improve patient care and reduce musculoskeletal injuries to nurses as part of the nursing strategy announced in August 2001.

9. Give ambulance attendants better access to training.

An enhanced basic training standard of qualification was initiated by the British Columbia Ambulance Service (BCAS) in 2001/02. The new level, Paramedic 1, is a nationally accredited training standard, and is being offered to 1,300 new recruits and part-time personnel. BCAS has also continued the delivery of training to paramedics to enhance the current base Emergency Medical Assistant 1 level to the Paramedic 1 standard. This will ensure paramedics have the necessary medical knowledge and skill to provide essential pre-hospital care and transportation in their communities

10. Fully fund and implement the $125 million mental health initiative.

On March 15, 2002, the Minister of State for Mental Health announced a $263 million funding plan to fulfill the Mental Health Plan commitment. At the end of six years $125 million will have been directed to improve community mental health services, and $138 million in capital funding will have been provided for Riverview Hospital redeployment and increased provincial tertiary capacity across the province.

11. Focus funding on patient care, by reducing waste in the system and eliminating administrative duplication and costs from provincial government mismanagement.

The number of health authorities has been reduced from 52 to 6 to achieve greater efficiency and avoid duplication, and the health ministries' administrative costs are being reduced by more than 40 per cent with those resources being redirected to patient care.

12. With IGR and Finance, negotiate with the federal government to restore all of the health care funding withdrawn through budget cuts.

In January 2002, the Premier of B.C. hosted an extraordinary meeting of all Canadian premiers to discuss health issues. The ministry worked closely with the Intergovernmental Relations Secretariat (IGR) in preparing for the meeting. At the meeting, the premiers confirmed the current level of federal funding contribution is inadequate to sustain quality health care. The issues of inadequate federal funding and the pressures facing provincial health care systems were also raised with the federal government at meetings of the conferences of Federal/Provincial/Territorial (F/P/T) Ministers of Health and F/P/T Deputy Ministers of Health.

13a. Fulfill BC's obligations under the *Canada Health Act* to properly fund and provide access to all medically necessary services.

The provincial health budget was increased by $1.1 billion in 2001/02.

13b. Maintain this year's overall $9.3 billion budget for health.

$9.5 billion was provided in the health ministries' budgets in 2001/02. On February 19, 2002, government tabled its 2002/03 budget, increasing the services

budget to $10.2 billion and health spending across government to $10.4 billion.

13c. Provide health regions and hospitals with three-year rolling funding commitments (updated annually), to enable them to plan and act with certainty.

Three-year rolling funding commitments were provided with the 2002/03 Budget announced in February 2002.

13d. Fund health regions at a level necessary to meet the needs of the people who live there, regardless of where a service is provided.

The ministry has introduced a population needs based funding formula for determining funding allocations to health authorities. The formula will be implemented in the 2002/03 fiscal year.

KEY PROJECTS

1. **Implement a monitoring system and accountability model for Regional Health Boards.**

Performance agreements have been developed which define expectations and performance deliverables for three fiscal years between health authorities and the Ministry of Health Services. The performance agreements will hold health authorities accountable for the delivery of patient care, patient outcomes and the allocation of funds. The agreements also contain major change requirements in areas of service such as emergency care, surgical services, home and community care, and mental health. In addition, a process is underway to establish core services in public and preventive health. The ministry will be monitoring health authorities on an ongoing basis to ensure compliance with the performance agreements.

2. **Develop a response plan for non-performing organizations.**

The ministry has established performance monitoring processes including the regular review of health authorities' reporting and performance, with a formal feedback loop if performance or reporting is unsatisfactory. The ministry and health authorities will also be engaging in routine, less formal contact regarding health authority performance.

3. **Prepare service plans for provincially delivered health services.**

As part of the new health authority structure implemented in December 2001, a Provincial Health Services Authority (PHSA) was established to manage and coordinate provincially delivered health services. Provincial health services refer to what the ministry has historically called tertiary services and provincial programs, i.e. those services which are either highly specialized and low volume and/or those services which are organized, funded and provided on a province-wide basis. The PHSA will work closely with the five new health authorities and the health ministries to ensure these programs are coordinated throughout the province, and that patient access issues are equitably addressed.

4. **With Health Planning, develop an information management strategy, focusing on health information for the general population and on data standards for regional health authorities.**

The Chief Information Officer (CIO) of the health ministries and the CIOs of the health authorities (Health CIO Council) are working together to finalize a strategic plan for Health Information Management in B.C. A key goal in the draft strategic plan is to make health information electronically available to British Columbians to help them improve wellness, learn about illnesses, find appropriate health services, and become informed of the best options and treatment practices.

B.C. is a leader in developing health information standards and some of the B.C.-approved standards have become national standards. The Health CIO Council has recently realigned the role of the B.C. Health Information Standards Council to put more emphasis on identifying and promoting standards and guidelines that will enable the sharing of health information in B.C.

5. **Cooperate with the Ministry of Children and Family Development on early childhood development initiatives.**

The ministry is a member of the Ministry of Children and Family Development's (MCFD) working group on Early Childhood Development. The ministry has worked with MCFD in meeting the reporting requirements of Health Canada related to the transfer of $291 million over five years to BC. These funds will be used to improve and expand early childhood development programs and services in key areas. As well, the ministry is providing leadership and collaborating with MCFD and other ministries in the development of the Best Chance Series, and the revision of the child health passport. This program supports parent action and responsibility for immunization, monitoring of growth and development, and attention to safety.

KEY PROJECTS FOR THE MINISTER OF STATE FOR INTERMEDIATE, LONG TERM AND HOME CARE

1. **Within the current budget allocation, and in coordination with Health Planning, ensure early action on intermediate, long-term and home care services.**

The ministry is developing a provincial strategy to optimize the health of persons with functional impairment due to aging, illness or disability. The ministry is working to achieve this through expanding and redesigning the home and community care system to provide services to a greater number of people, be more flexible and responsive, and more cost-effective. The objectives are to improve the assessment process, streamline access to services, support clients to remain independent in their homes for as long as possible and develop affordable housing based care options.

In the past year a new provincial standardized assessment tool has been introduced which will result in the right care being provided to the right client at the right time. This new tool is a critical component of effective case management, planning, resource allocation and outcome measures and is now being implemented by the health authorities.

The ministry has also been working with BC Housing on a supportive living initiative. This initiative will allow low and modest income seniors and people with disabilities to access support services in a home setting.

2. **Serve as the point person for those wishing to make representation on issues related to continuing care.**

The Minister of State for Intermediate, Long Term and Home Care meets regularly with various individuals and industry representatives on a broad range of issues affecting home and community care services. The minister also works closely with other ministries and BC Housing, and makes presentations to Cabinet, inter-ministry committees and the Government Caucus Committee on Health on home and community care issues.

3. **Establish a new and cost-effective strategy to provide 5,000 new intermediate and long-term care beds over the next five years.**

This commitment forms part of the ministry's overall strategy for home and community care. The ministry has been working with BC Housing on a supportive living initiative which will allow low and modest income seniors and people with

disabilities to access support services in a home setting. The initiative calls for 3,500 supportive living units across the province: 1,500 new units will be constructed, 1,000 existing units will be converted, and 1,000 rent supplements will be provided to enable seniors and people with disabilities to live in supportive living units. It is a significant first step in meeting the goal of 5,000 beds.

KEY PROJECTS FOR THE MINISTER OF STATE FOR MENTAL HEALTH

1. **Within the current budget allocation, and in coordination with Health Planning, ensure early action on mental health services.**

In the last year, government announced a $263 million action plan to revitalize services and facilities for people with mental health problems. In addition, specific Mental Health Plan requirements for tertiary re-development, including Riverview Hospital re-development, early diagnosis of illness, decreases in alternate level care days, and follow-up in the community after hospital discharge have been included in the health authorities' performance agreements as 'must-do' requirements.

2. **Become the advocate for mental health services throughout government.**

The Minister of State for Mental Health is working with various ministries such as the Ministry of Human Resources, Ministry of Children and Family Development, Ministry of Public Safety and Solicitor General, Ministry of Attorney General and Treaty Negotiations, Ministry of Education and Ministry of Advanced Education, as well as consumers, families, health authorities, provincial mental health organizations and other partners to improve understanding of mental illness, the availability of effective treatment based on evidence and the need to build appropriate services and supports for people with mental illness. The minister also makes presentations to Cabinet, inter-ministry committees and the Government Caucus Committee on Health on mental health issues.

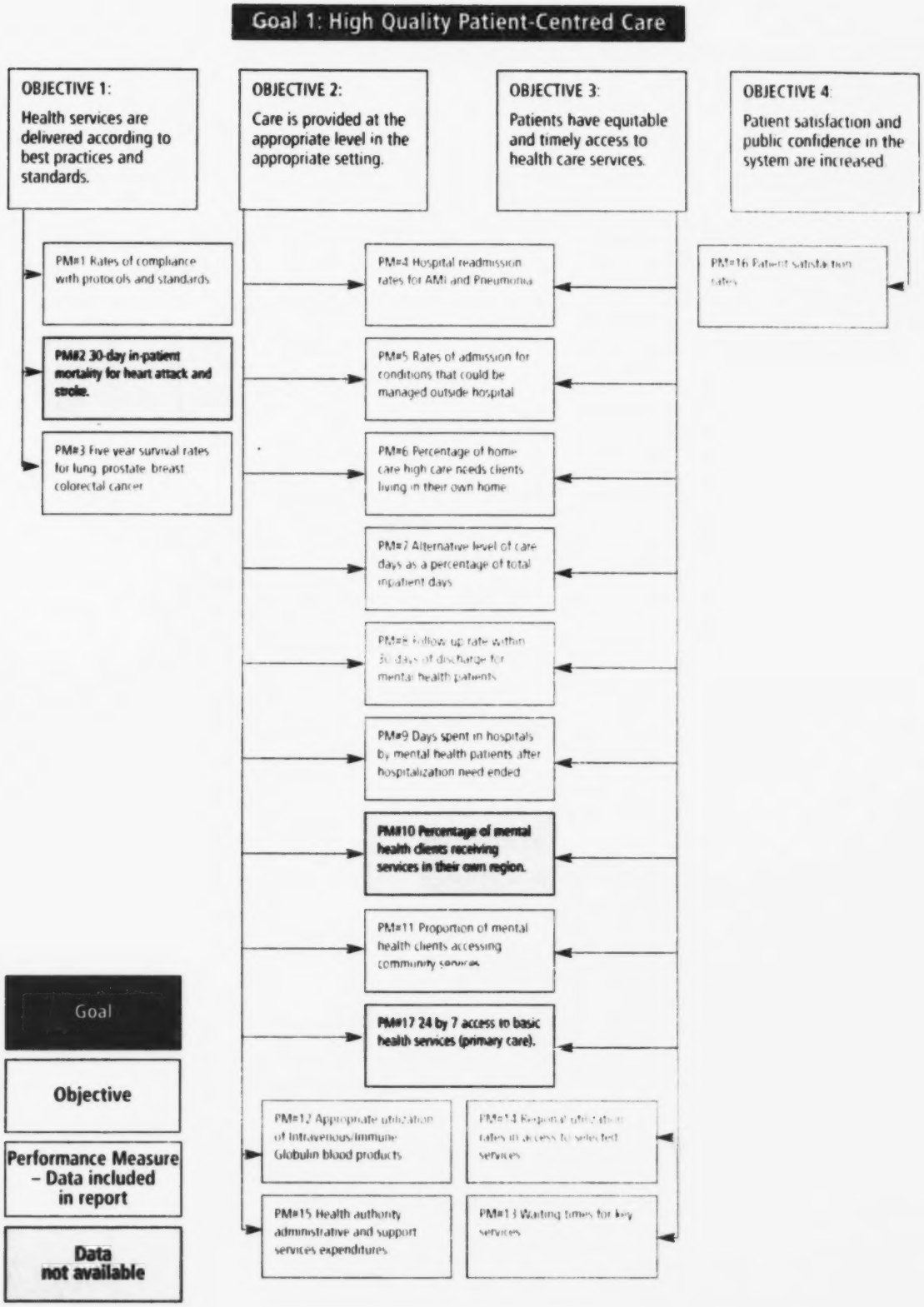
3. **Establish a public information program on mental health issues and community services in cooperation with other government agencies, professional bodies and community groups.**

A public information strategy is under development. The program is expected to be announced in 2002 following consultation with mental health stakeholders.

PERFORMANCE REPORTING

In February 2002, the Minister of Health Services tabled the ministry's 2002/03-2004/05 service plan in the Legislature. It includes a wide set of targets and performance measures that help track progress in meeting the ministry's goals and objectives. This year's annual service plan report provides information on those performance measures. However, since this is a year of transition to a new reporting structure, this year's results are intended to serve as background data for future tracking and reporting. Beginning next year, actual results for performance measures will be compared against the performance targets established for that year.

Tracking and reporting how well the health care system is doing in meeting its performance objectives is one of the responsibilities outlined in the *Budget Transparency and Accountability Act*, amended in August 2001. The ministry is committed to ensuring British Columbians get the greatest health benefit possible for every tax dollar devoted to health care. Performance measurement is one way to keep track of the quality, accessibility and appropriate delivery of these services. It also helps to monitor the effectiveness of the programs in improving the health and wellness of British Columbians. And finally, the measures help to determine how efficient the health sector is in delivering those services. Knowing how well the ministry is performing in meeting its goals is the first step toward making continuous and meaningful improvements.


Goal 1: High Quality Patient-Centred Care
OBJECTIVE 1:
Health services are delivered according to best practices and standards.
OBJECTIVE 2:
Care is provided at the appropriate level in the appropriate setting.
OBJECTIVE 3:
Patients have equitable and timely access to health care services.
OBJECTIVE 4:
Patient satisfaction and public confidence in the system are increased.
PM#1 Rates of compliance with protocols and standards
PM#2 30-day in-patient mortality for heart attack and stroke.
PM#3 Five year survival rates for lung, prostate, breast, colorectal cancer
PM#4 Hospital readmission rates for AMI and Pneumonia
PM#5 Rates of admission for conditions that could be managed outside hospital
PM#6 Percentage of home care high care needs clients living in their own home
PM#7 Alternative level of care days as a percentage of total inpatient days
PM#8 Follow up rate within 30 days of discharge for mental health patients
PM#9 Days spent in hospitals by mental health patients after hospitalization need ended
PM#10 Percentage of mental health clients receiving services in their own region.
PM#11 Proportion of mental health clients accessing community services
PM#17 24 by 7 access to basic health services (primary care).
PM#16 Patient satisfaction rates
PM#12 Appropriate utilization of Intravenous/Immune Globulin blood products
PM#14 Report of utilization rates in access to selected services
PM#15 Health authority administrative and support services expenditures
PM#13 Waiting times for key services
Goal
Objective
Performance Measure – Data included in report
Data not available

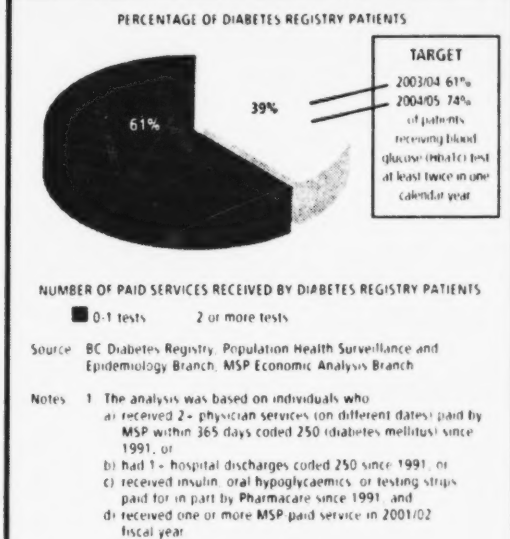
PM#1 – Rates of compliance with selected protocols and standards

This indicator measures the proportion of patients known to suffer from a chronic disease who receive services according to standards set out in protocols and guidelines developed by professionals. This year the measure will focus on diabetes. Future measures will assess the increase in the number of known patients with heart disease (congestive heart failure), asthma, depression, renal failure, and hypertension, who receive specified services within specified intervals.

Diabetes is one of the most common chronic diseases, affecting about five per cent of Canadians. Its prevalence is expected to increase significantly due to an aging population and increased rates of obesity. Efforts to control hyperglycemia, hypertension and dyslipidemia can prevent or postpone the development of complications in persons with diabetes. The B.C. diabetes guidelines, which have been adopted and shared with physicians and patients, outline strategies to help the primary care practitioner meet the complex needs of persons with diabetes, and in particular recommend tests that permit identification and control of problems and complications. One such test is blood glucose testing (Hba1c) which is recommended at least twice a year.

Data for 2001/02 reveal that of the nearly 175,000 patients on the Diabetes Registry, only 38.5 per cent received the blood glucose testing at least twice annually as recommended in the guidelines. The majority (61.5 per cent) of patients known to suffer from diabetes received the test once or not at all.

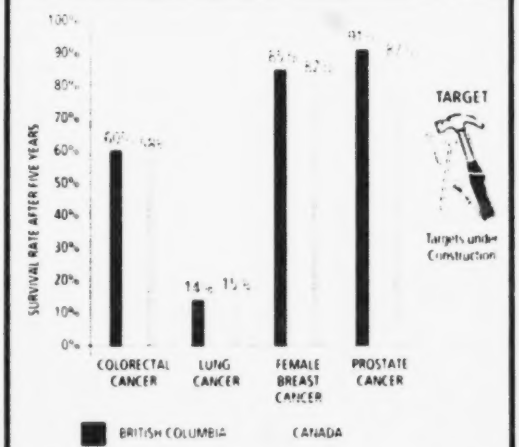
NUMBER OF TIMES PER YEAR PATIENTS RECEIVED BLOOD GLUCOSE TESTING (Hba1c), 2001/02


PERCENTAGE OF DIABETES REGISTRY PATIENTS
61%
39%
TARGET
2003/04 61%
2004/05 74%
of patients receiving blood glucose (HbA1c) test at least twice in one calendar year
NUMBER OF PAID SERVICES RECEIVED BY DIABETES REGISTRY PATIENTS
0-1 tests
2 or more tests

Source: BC Diabetes Registry, Population Health Surveillance and Epidemiology Branch, MSP Economic Analysis Branch

Notes:
1. The analysis was based on individuals who
   a) received 2+ physician services (on different dates) paid by MSP within 365 days coded 250 (diabetes mellitus) since 1991, or
   b) had 1+ hospital discharges coded 250 since 1991, or
   c) received insulin, oral hypoglycaemics, or testing strips paid for in part by Pharmacare since 1991, and
   d) received one or more MSP paid service in 2001/02 fiscal year

FIVE-YEAR RELATIVE SURVIVAL RATE FOR CANCER CASES, POPULATION AGED 15-99, 1997



Source: Statistics Canada, Canadian Cancer Registry, Canadian National Mortality Data Base, and Canadian and provincial life tables 1990, 1992, 1150

Notes:
1. World Health Organization, International Classification of Diseases, 9th Revision (ICD-9)
2. If a patient was diagnosed with more than one invasive tumour in 1992, only the tumour recorded with the earliest date of diagnosis was retained

PM#3 Five-year survival rates for lung, prostrate, breast, colorectal cancer

Five-year relative survival rates for cancer is defined as the proportion of individuals diagnosed with a particular type of cancer surviving for a five-year period relative to the survival of the general population with the same characteristics of age, gender and province of residence. This is a standard "yardstick" used in oncology to assess the effectiveness of treatment. In essence, it

measures the probability of avoiding death from cancer for five years after the initial diagnosis. It is generally held that if one can remain disease-free for five years, the probability of long-term survival is much improved.

Cancer survival rates are influenced by two main groups of factors: (1) the severity (stage) of the cancer at the time of diagnosis, and (2) the effectiveness of cancer treatment after diagnosis. Therefore, an improvement in survival rates over time or in comparison to other regions may be the result of either or both of these groups of factors. Longer survival rates may result from improvements in early detection or from more effective treatments after diagnosis, or both, and are a useful measure for indicating improvements in these areas.

Of the B.C. residents diagnosed with colorectal cancer in 1992, 60 per cent were as likely to live another five years as were B.C. residents of the same gender and age in the general population. B.C. residents diagnosed with lung cancer in 1992 were 14 per cent as likely to live another five years as the general population. The five-year relative survival rate was 85 per cent for B.C. residents diagnosed with breast cancer in 1992 and 91 per cent for those diagnosed with prostate cancer in 1992. In all cases, the rates observed in B.C. are similar to those for the country overall. The slight differences are not statistically significant.

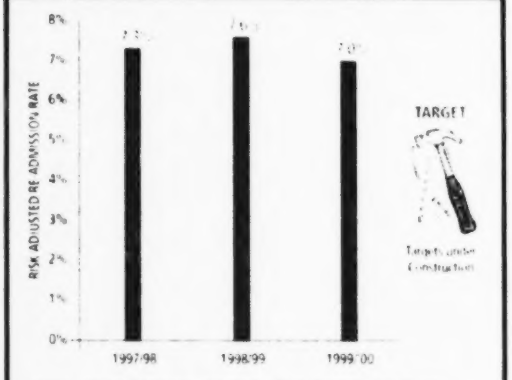
PM#4- Hospital re-admission rates for heart attack (acute myocardial infarction) and pneumonia

A. Acute Myocardial Infarction Re-admission Rate

Acute myocardial infarction (AMI) is the medical term for a heart attack. This indicator measures the rate of re-admissions to hospitals that occur within 28 days of discharge and that result from complications or an adverse occurrence after discharge from hospital care.

It is designed to provide information about the level of safety and quality care in heart

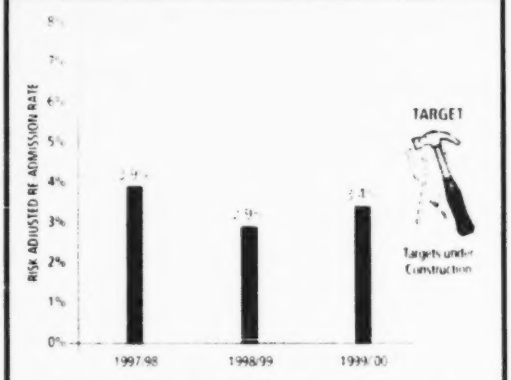
HEART ATTACK (ACUTE MYOCARDIAL INFARCTION) RE-ADMISSION RATE, B.C., 1997/98 – 1999/00



Source: Hospital Morbidity Database, Canadian Institute for Health Information

Notes: Risk adjusted rate of unplanned re-admission following admission for Acute Myocardial Infarction (AMI). A case is counted as a re-admission if it is for a relevant diagnosis or procedure and occurs within 28 days after the index AMI episode of care. An episode of care refers to all continuous care hospitalization including transfers.

PNEUMONIA RE-ADMISSION RATE, B.C., 1997/98 — 1999/00



Source: Hospital Morbidity Database, Canadian Institute for Health Information

Notes: Risk adjusted rate of unplanned re-admission following admission for pneumonia. A case is counted as a re-admission if it is for a relevant diagnosis or procedure and occurs within 28 days after the index pneumonia episode of care. An episode of care refers to all continuous care hospitalization including transfers.

health care services. The rate of re-admissions may also be an indicator of the effectiveness of heart health education programs. For example, if a person seeks treatment early in response to symptoms, there is likely less chance of complications later on.

Over recent years, while the number of AMI cases in B.C. hospitals rose slightly to 6,420 in 1999/00, the rate of AMI hospital re-admissions was fairly stable.

B. Pneumonia Re-admission Rate

This indicator measures the rate of re-admissions to hospitals that occur within 28 days of discharge and that result from complications or an adverse occurrence after discharge from hospital care. The measure is a broad indicator of the level of quality care provided in hospitals.

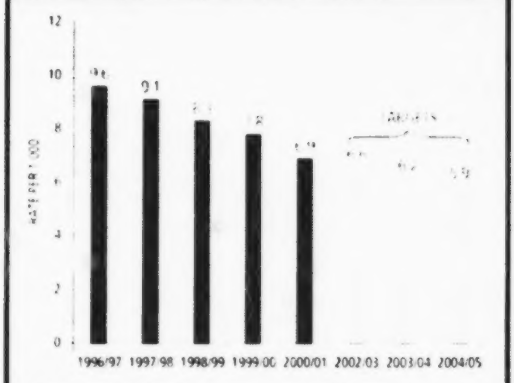
The number of hospitalizations due to pneumonia in the province was relatively constant over the three years beginning 1997/98, at about 10,850 in each year. Unplanned re-admission rates declined slightly.

PM#5 - Rate of hospital admission for conditions that could be managed outside hospitals

This indicator shows the extent to which services provided on an in-patient basis in an acute care hospital may have been managed outside of hospitals.

People admitted to hospital for conditions that usually do not need hospitalization are classified as 'May Not Require Hospitalization' or MNRH. This label is determined at a national level by the Canadian Institute for Health Information, and is consistently applied across the country. An example of an MNRH case would be an admission for corneal lens replacement, an operation that is almost always done as an out-patient (day care) procedure. The label 'MNRH' does not mean that no such cases should be admitted - there may be other reasons for admission if the patient has another existing condition that would make the normal type of care less safe. However, taken as a group they give some idea of the overall appropriateness of admissions to hospital.

RATE OF HOSPITAL ADMISSIONS PER 1,000 FOR MAY NOT REQUIRE HOSPITALIZATION, B.C., 1996/97 – 2000/01



Source: Discharge Abstract Database, Information Support

Notes: 1. This report was produced using discharges from acute and rehabilitation care levels (no newborns).
2. Data has been restricted to May Not Require Hospitalization (MNRs) CMG's.

The bar chart shows that the rate of patient admissions that were classified as MNRH has dropped steadily over recent years, from 9.6 cases per 1,000 hospital admissions in 1996/97 to 6.1 cases per 1,000 hospital admissions in 2000/01, or by 28 per cent. Since the total rate of hospital admissions dropped by 10 per cent over the same period, the proportion of cases classified as MNRH that are being admitted to hospital is also dropping. This change shows that the appropriateness of hospital admissions, as measured by this indicator, is improving.

PM#6 - Percentage of home and community care clients with high care needs, living in their own home rather than a residential care facility.

This indicator measures the use of home-based care in relation to facility-based care for home and community care (HCC) clients with high care needs. These clients include people assessed at the intermediate care level 2 or higher.

One of the goals of the HCC service sector is to deliver services that are more appropriate, efficient and effective in meeting the assessed needs of clients. This will also result in a more appropriate use of residential and acute care services. HCC clients are increasingly expecting services that maintain their independence in their

own homes for as long as possible. For this to occur, there needs to be a shift in service provision towards home-based care. The information will assist in planning HCC services that delay or prevent inappropriate admissions to residential care and acute care hospitals, and support early discharge from hospitals.

In 2000/01, 42.3 per cent of HCC clients with high care needs were living in their own home rather than a residential care facility. This is essentially the same percentage as for 1999/00. Prior to then, the indicator had been increasing from about 1.5 per cent to 4.0 per cent per year. This shows that the use of home care for clients with high care needs, as measured by this indicator, is improving.

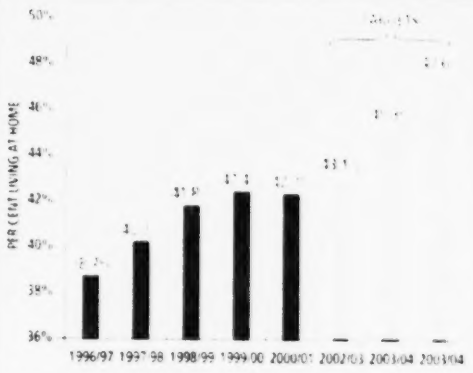
PM#7 - Alternate level of care days as a percentage of total inpatient days.

This indicator measures the number of days that Alternate Level of Care (ALC) patients spend in acute care hospitals, as a proportion of all in-patient hospital days. ALC patients are those who no longer require acute care services but are waiting in an acute care bed pending completion of discharge arrangements, or placement in an alternate service setting such as a residential care facility or community based services.

The measure is designed to indicate whether patients have timely access to the most appropriate care setting. The inappropriate use of acute care beds suggests potential issues with availability and access to alternate types of care or difficulties with discharge planning. It also suggests that management of acute care beds could be improved.

In 2000/01, ALC days accounted for 15.4 per cent of total in-patient days. Other than a slight decrease in the percentage in 1999/00, this indicator has been increasing since 1996/97 when it was 10.8 per cent. This suggests that improvements are necessary to ensure timely access to the most appropriate care setting for British Columbians, as measured by this indicator.

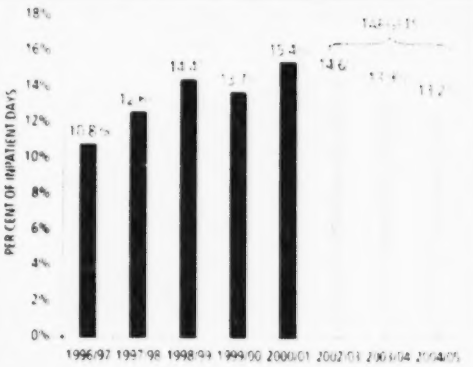
PERCENTAGE OF HOME & COMMUNITY CARE CLIENTS IN B.C. WITH HIGH CARE NEEDS LIVING AT HOME RATHER THAN IN A RESIDENTIAL CARE FACILITY, 1996/97 - 2000/01



Source: Continuing Care Information Management Systems, Continuing Care Data Warehouse

Notes: 1. HCC clients at home refer to those receiving home support and adult day care. Those in residential care facilities refer to those in residential, group homes, and family care, and excludes mental health care.
2. Counts of clients are made at a point in time. Data shown in the table are for Oct. 1st of each year.

ALTERNATE LEVEL OF CARE DAYS (ALC) AS A PERCENTAGE OF TOTAL INPATIENT DAYS, B.C., 1996/97 — 2000/01



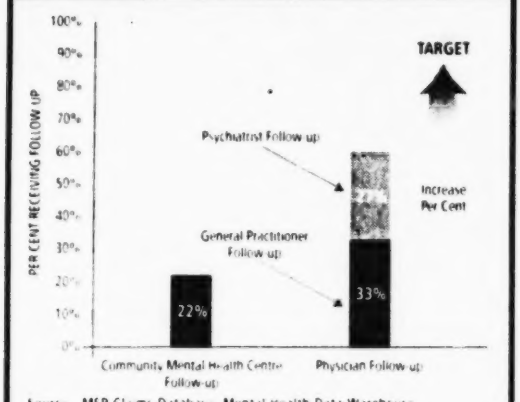
Source: Discharge Abstract Database, Information Support

Notes: 1. Total inpatient days include acute care, rehabilitation and alternate level of care. Includes planning and actuals.
2. ALC days include all days identified as level of care in facility planning.
3. The data includes Psychiatry, Surgery, and Medicine specialties only.

PM#8: Improved continuity of care measured by the proportion of persons hospitalized for a mental health diagnosis who receive community or physician follow-up care within 30 days of discharge

This indicator shows the extent to which people who have been hospitalized for a mental health diagnosis receive community or physician follow-up within 30 days of discharge.

COMMUNITY FOLLOW-UP WITHIN 30 DAYS OF HOSPITAL DISCHARGE, 1999/00



Source: MSP Claims Database, Mental Health Data Warehouse, Client/Patient Information Management (CPIM) System, Discharge Abstract Database, Information Support

It is designed to measure changes in continuity of care for people with a mental health diagnosis. A high rate of follow up care indicates that services are well-coordinated and community or physician services are available and accessible. Improvements in continuity of care are expected to improve quality health outcomes and reduce the need for hospital re-admissions soon after discharge from a hospital.

In 1999/00, approximately 82 per cent of the patients discharged from hospitals with a primary mental health diagnosis received community or physician follow up care within 30 days of discharge. Approximately 33 per cent of the clients received follow-up care from general practitioners; 27 per cent from psychiatrists; and 22 per cent from community mental health centres.

The follow-up rate for community mental health centres declined from 26 per cent in 1997/98 to 22 per cent in 1999/00. This is partially attributable to discontinued reporting by some health authorities in 1999/00. The community mental health centre follow-up rate varies significantly between "open cases" and "new cases." For clients who were already registered with community mental health centres in 1999/00 (open cases), the follow up rate was around 40 per cent compared to a 12 per cent rate for new cases.

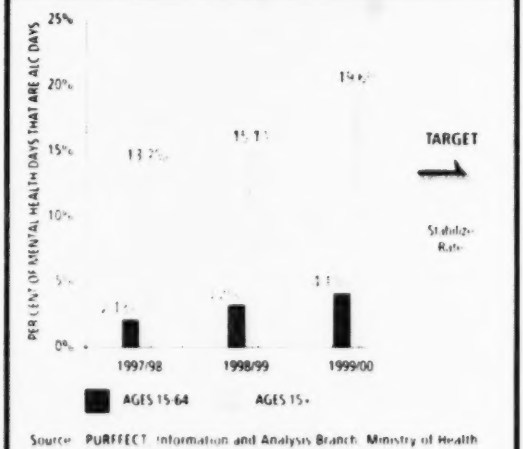
PM# 9: Percentage of days spent by mental health clients in hospitals after the need for hospital care ended

This indicator measures the number of days spent by mental health clients in hospitals after the need for hospital care ended.

It is designed to provide information about the availability of community services and the appropriate provision of services consistent with the needs of the clients. This also reflects the cost-effective use of hospital and community resources.

Over the past three years, the number of days spent by adult mental health clients

MENTAL HEALTH ALTERNATE LEVEL OF CARE (ALC) DAYS, 1997/98 – 1999/00



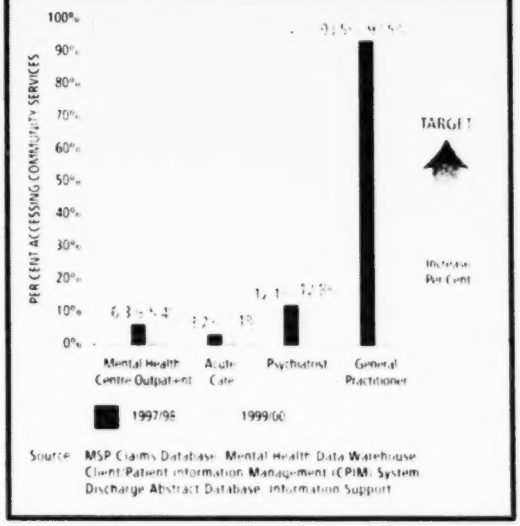
Source: PURFFECT Information and Analysis Branch, Ministry of Health Services

Notes: 1 Diagnostic information based on ICD9
2 For 1999/00 and later, ALC includes all days coded alternate level of care or discharge planning

(15-64 age group) in Alternate Level of Care (ALC) has doubled. In 1997/98, mental health clients spent 2.1 per cent of the acute care and rehabilitation days in ALC; by 1999/00, it increased to 4.1 per cent.

As shown in the chart on previous page, if the scope of the analysis is expanded to include the older population, a significant number of mental health clients seems to spend days in ALC. In 1997/98, mental health clients (15+ age group) spent 13.7 per cent of the hospital stay in ALC. By 1999/00, it increased to 19.6 per cent. This suggests that improvements are necessary to ensure the availability of community services and the appropriate provision of services consistent with the needs of mental health clients, as measured by this indicator.

PERCENTAGE OF MENTAL HEALTH CLIENTS ACCESSING COMMUNITY SERVICES, B.C., 1997/98 — 1999/00



Source: MSP Claims Database, Mental Health Data Warehouse, Client/Patient Information Management (CPIM) System, Discharge Abstract Database, Information Support

PM#11: Proportion of mental health clients accessing community services

This indicator measures the percentage of mental health clients accessing community services. It is designed to reflect the availability of community services.

The majority of mental health clients in British Columbia receive community mental health services from mental health centres or physicians. However, the number and the type of services they receive vary depending upon service availability and the nature and severity of mental illness.

In 1997/98, approximately 574,000 British Columbians over the age of 15 made contact with the mental health system for a primary diagnosis of mental illness. Of these 574,000 clients, over 96.8 per cent received at least one community mental health service. By 1999/00, the number of mental health clients increased to 606,872 and over 96.9 per cent of these clients received some form of community service either from a mental health centre or a physician.

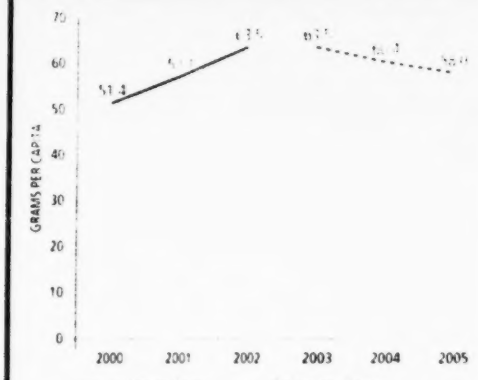
This indicator suggests that the availability of community services has remained fairly stable with about 97 per cent of clients accessing services, despite an increase in overall mental health clients over the age of 15.

As shown in the graph above, approximately 93.5 per cent of the mental health clients visit general practitioners and about 12.5 per cent receive services from psychiatrists. This pattern of use has been fairly stable over the three-year period 1997/98 to 1999/00. On the other hand, there appears to be a 14.3 per cent drop in the number of mental health clients making contact with community mental health centres. In 1997/98, 6.3 per cent of the clients received services from community mental health centres, by 1999/00, it dropped to 5.4 per cent. This drop is largely attributable to discontinued reporting by some health authorities.

PM#12 Appropriate use of blood products: use of intravenous immune globin

This indicator measures the use of intravenous immune globulin (IVIG), a fractionated blood product manufactured from human plasma. It is licensed for use in the treatment of a small number of clinical indications. It is also used to treat a growing range of unlicensed conditions.

UTILIZATION RATES OF IVIG (GRAMS PER CAPITA), B.C., 2000 – 2002



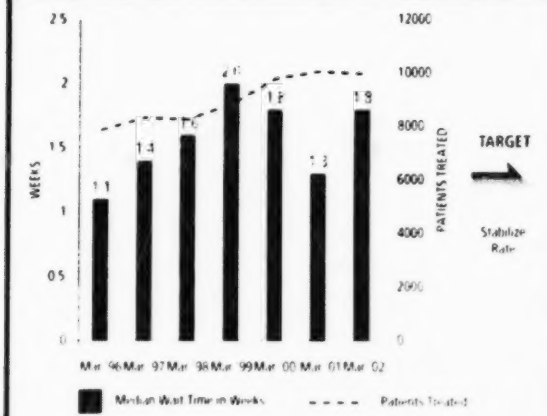
Source: Canadian Blood Services

Some of these applications have a strong foundation in the medical literature while others have less conclusive basis in evidence, or no basis at all.

A study examining usage of IVIG in British Columbia in 1999 found approximately 20 per cent of the usage was for conditions where IVIG therapy was not indicated. This study clearly suggests there is scope for curbing unwarranted IVIG use in the province. The average cost of IVIG is approximately $70 per gram and the cost per course of treatment regularly exceeds $10,000.

The chart shows that the use of IVIG in B.C. has increased over the past three years, from 51.4 grams per capita in 2000 to 63.5 grams per capita in 2002. Through the Provincial Blood Coordinating Office, the Ministry of Health Services is implementing an IVIG Utilization Management Project to monitor the appropriate use of IVIG with the goal of stabilizing and reducing usage.

CANCER – RADIOTHERAPHY MEDIAN WAIT TIMES AS AT MARCH 31 ANNUAL PATIENTS TREATED, 1995/96 – 2001/02



Patients Treated	Mar 96	Mar 97	Mar 98	Mar 99	Mar 00	Mar 01	Mar 02
	7877	8334	8268	8840	9782	10063	9985

Source: B.C. Cancer Association

Notes: The median wait time is measured as the point at which half of patients will have a shorter wait and half will have a longer wait. Median waits are based on actual days waited by all patients who received the procedure within each quarter.

PM#13 – Waiting times for key services (cancer, cardiac, hip and knee replacement)

A. Waiting times - Cancer Services

This indicator measures the percentage of patients that begin radiotherapy within four weeks of being ready to treat and that begin chemotherapy within two weeks of being ready to treat. This is based on median wait times for these services and the number of patients treated. Monitoring wait times helps to ensure patients' cancers are treated as early as possible so as to provide the best outcomes.

The expansion of the Victoria Cancer Clinic has increased the number of radiotherapy machines in B.C. As a result, radiotherapy services will be able to meet increasing demands for these services over the next few years. Planning for an additional clinic in Abbotsford within the next four to five years will help ensure provincial services keep up with the growing incidence of cancer.

In almost all instances, except for patients requiring some additional tests or preliminary treatment, patients requiring chemotherapy for their cancer receive it within one to two weeks. Therefore, the province is already meeting next year's performance target of 90 per cent of patients requiring chemotherapy within two weeks of being ready to treat.

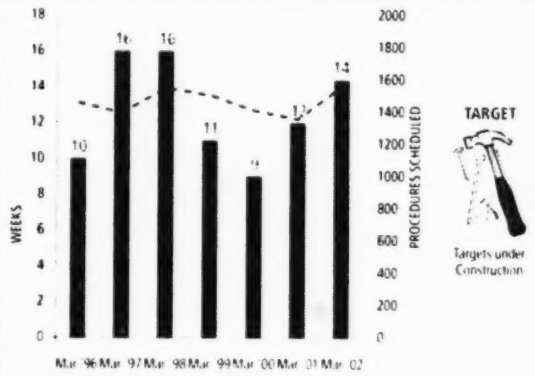
As of March 2002, 88 per cent of patients requiring radiotherapy started treatment within four weeks of being determined to be "ready to treat." The performance standard of 90 per cent within four weeks was almost met. There are some patients deemed ready to treat who require additional time for them to make the decision to proceed with therapy or to seek alternative care.

B. Waiting times – Cardiac Surgery

This indicator measures the median wait times for scheduled cardiac (heart) surgery. This category covers a range of cardiac procedures, such as coronary artery bypass surgery, valve surgery, congenital heart disease and operations of the aorta.

This indicator is designed to monitor the change in wait times in an effort to ensure patients have timely access to cardiac surgery. This will become more critical as demand for these surgeries increases, due in part to the aging population.

CARDIAC SURGERY
MEDIAN WAIT TIMES AS AT MARCH 31
ANNUAL SCHEDULED PROCEDURES, 1996/97 – 2001/02

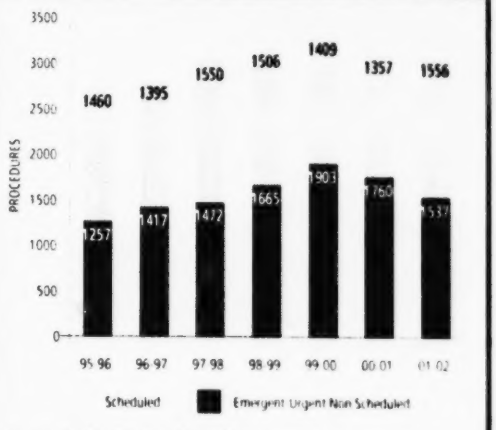

WEEKS
PROCEDURES SCHEDULED
TARGET
Targets under Construction
Mar 96 Mar 97 Mar 98 Mar 99 Mar 00 Mar 01 Mar 02
Median Wait Time in Weeks
Patients Treated

Patients Treated	Mar 96	Mar 97	Mar 98	Mar 99	Mar 00	Mar 01	Mar 02
	1460	1395	1550	1506	1409	1357	1556

Source: Cardiac Registry submitted from hospitals

Notes:
1. Excludes emergency urgent non-scheduled procedures, as there is virtually no wait for emergency cases. Emergency cases represent about half of all cardiac surgeries performed in B.C.
2. The median wait time is measured as the point at which half of patients will have a shorter wait and half will have a longer wait. Median waits are based on actual days waited by all patients who received the procedure within each quarter.

CARDIAC SURGERY (ALL)
PROVINCIAL TOTALS, 1995/96 – 2001



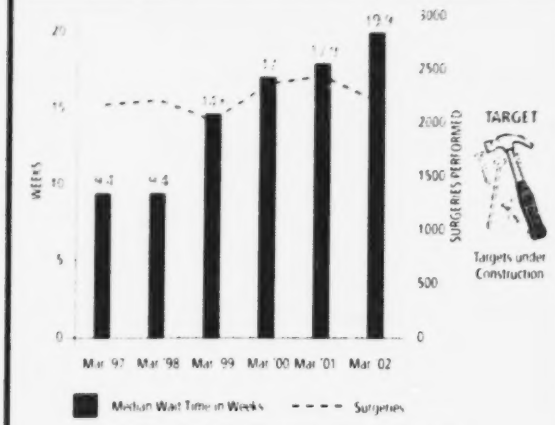
Source: Cardiac Registry submitted from hospitals

About half of all cardiac surgeries performed in the province are emergency cases. There is virtually no wait for emergency cases.

In recent years, the access times for 'scheduled' cardiac surgeries have lengthened. In 2001/02, the median wait time for scheduled cardiac surgery was 14.4 weeks, up from a median of 10 weeks in 1995/96. The increased access time is due in part to nursing staff shortages (particularly in critical care), which have reduced the ability of the cardiac surgery program to deliver all of the funded cases in each of the last four years.

In the last two years, the number of scheduled cases on the waitlist has decreased. Coronary angioplasty, an alternative to coronary bypass graft surgery in some cases, has expanded significantly in recent years, from 3,000 cases in 1995/96 to over 4,700 in 2001/02. The development of alternative treatments has helped to keep the number of cases on the waitlist for cardiac surgery in control.

HIP REPLACEMENT SURGERY
MEDIAN WAIT TIMES AS AT MARCH 31
ANNUAL SCHEDULED PROCEDURES, 1996/97 – 2001/02

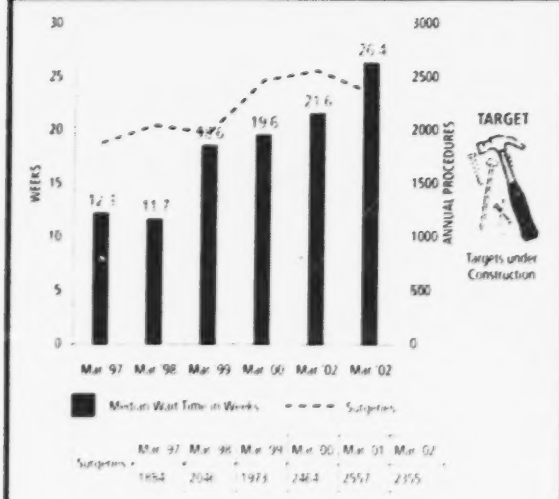


Surgeries	Mar '97	Mar '98	Mar '99	Mar '00	Mar '01	Mar '02
	2174	2216	2027	2366	2441	2205

Source: Waitlist registry submitted from hospitals

Notes: The median wait time is measured as the point at which half of patients will have a shorter wait and half will have a longer wait. Median waits are based on actual days waited by all patients who received the procedure within each quarter.

KNEE REPLACEMENT SURGERY
MEDIAN WAIT TIMES AS AT MARCH 31
ANNUAL SCHEDULED PROCEDURES, 1996/97 – 2001/02



Surgeries	Mar '97	Mar '98	Mar '99	Mar '00	Mar '01	Mar '02
	1854	2048	1973	2483	2557	2355

Source: Waitlist registry submitted from hospitals

Notes: The median wait time is measured as the point at which half of patients will have a shorter wait and half will have a longer wait. Median waits are based on actual days waited by all patients who received the procedure within each quarter.

C. Waiting times – Hip and Knee Replacement Surgery

This indicator measures the median wait time for hip and knee replacement surgery. Tracking wait times is done in an effort to ensure timely access to these procedures.

Over the last five years there has been a significant rise in the median waiting times for surgery for both of these services. At the same time the number of procedures performed over time has been relatively constant for hip replacement surgery and moderately increased for knee replacement surgery.

There is a greater demand for these surgeries because of expanded eligibility criteria in addition to population growth and aging. Also, disruptions to the health care system by job action and nursing staff shortages have meant longer access time to services for chronic conditions so as to maintain emergency and urgent care for the more acute conditions.

In 2001/02, the median wait time for hip surgery was 19.9 weeks, significantly up from the 9.4 weeks wait time in 1996/97. The median wait time for knee surgery in 2001/02 was 26.4 weeks, up from 12.3 weeks in 1996/97. Restructuring of the health care system will enable health authorities to address this issue and provide more timely access.

PM #14 - Regional utilization rates of selected services (hip, knee, cardiac)

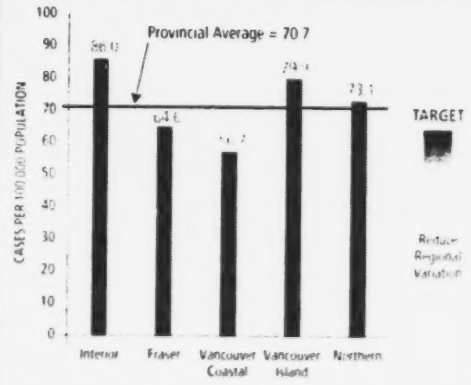
This indicator measures utilization rates of hip replacement, knee replacement and coronary artery bypass graft surgeries for various provincial regions. Measuring these regional rates is one way to compare the level of access to services among regions in an effort to ensure equal access for all to quality health care.

A. Hip Replacement Surgeries

In 2000/01, there were 70.7 hip replacement surgeries performed for every 100,000 residents of the province. Comparing age-adjusted rates (which take into consideration the population demographics in each health authority), residents of the Interior had the highest rate of hip replacement surgeries (86.0) and residents of Vancouver had the lowest (56.7).

The target for this indicator is that the rates of services should be within 10 per cent of the provincial average.

HIP REPLACEMENT SURGERY RATE (CASES PER 100,000 POPULATION) 2000/01



Source: Discharge Abstract Database, Information Support, Population tables from PEOPLE26, BC Stats

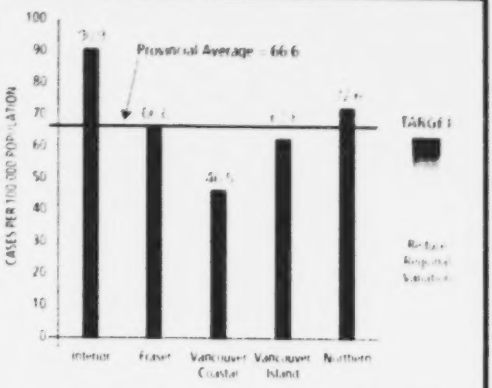
Notes: 1. The rates are per 100,000 age-adjusted population
2. Residents of B.C. treated out of province are included. Non-BC residents are excluded.

B. Knee Replacement Surgeries

In 2000/01, there were 66.6 knee replacement surgeries performed for every 100,000 residents of the province. Comparing age-adjusted rates (which take into consideration the population demographics in each health authority), residents of the Interior had the highest rate of knee replacement surgeries (91.0) and residents of Vancouver had the lowest (46.5).

The target for this indicator is that the rates of services should be within 10 per cent of the provincial average.

KNEE REPLACEMENT SURGERY RATE (CASES PER 100,000 POPULATION) 2000/01



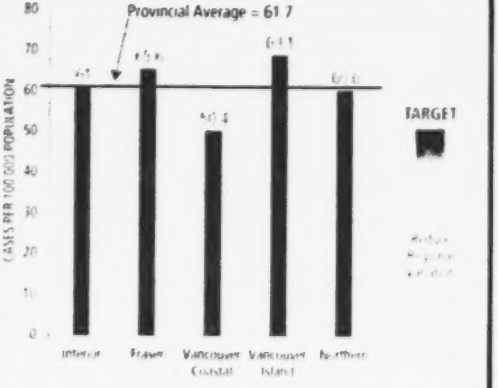
Source: Discharge Abstract Database, Information Support, Population tables from PEOPLE26, BC Stats

Notes: 1. The rates are per 100,000 age-adjusted population
2. Residents of B.C. treated out of province are included. Non-BC residents are excluded.

C. Coronary Artery Bypass Graft (CABG) Procedures Rate

In 2000/01, there were 61.7 coronary artery bypass graft (CABG) procedures performed for every 100,000 residents of the province. Comparing age-adjusted rates, which take into consideration the population demographics in each health authority.

CORONARY ARTERY BYPASS GRAFT (GABC) PROCEDURES RATE (CASES PER 100,000 POPULATION) 2000/01



Source: Discharge Abstract Database, Information Support, Population tables from PEOPLE26, BC Stats

Notes: 1. The rates are per 100,000 age-adjusted population
2. Residents of B.C. treated out of province are included. Non-BC residents are excluded.

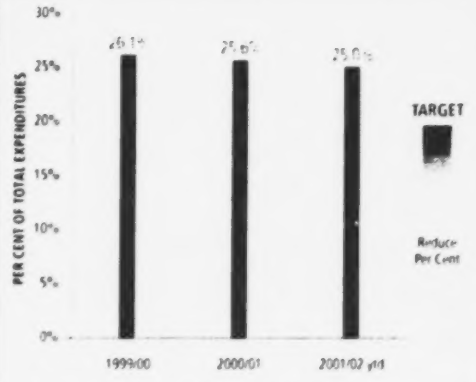
residents of the Vancouver Island region had the highest rate of CABG surgeries (69.1) and residents of Vancouver had the lowest (50.4).

The target for this indicator is that the rates of services should be within 10 per cent of the provincial average.

PM#15 – Health Authority administrative and support services expenditures as a percentage of total expenditures

This indicator measures the percentage of total health authority expenditures represented by administrative support services, in an attempt to encourage regional health authorities to ensure that every available dollar is directed towards patient care. Administrative services include functions such as finance, human resources, communications, and plant administration. Support services refer to areas such as materiel management, laundry and linen, plant operations, plant security, plant maintenance and food services.

HEALTH AUTHORITY ADMINISTRATION AND SUPPORT EXPENDITURES, 1999/00 – 2001/02



Source: Health Authority Management Information System Information and Support Branch

Notes: 1. Administration and support expenditures include functional centres for administration and support as defined by CIHI plus functional centres for nursing inpatient services, ambulatory care and community to ensure consistency with industry analysis, and excludes systems support.
2. Total expenditures exclude amounts for contracted service providers.
3. Result for 2001/02 is based on information available at time of compilation of this report, and may not reflect final expenditure information, including restructuring costs recognized during 2001/02.

By reducing the number of health authorities from 52 to six in 2001/02, encouraging shared services, and providing new tools for management of human resources (Bill 29 – *The Health And Social Services Delivery Improvement Act*), it is expected that health authorities will be able to provide the same level and quality of services in a much more cost-effective manner.

The bar chart shows that over the last three years the proportion of expenditures on administrative and support services has declined from 26.1 per cent in 1999/00 to 25.0 per cent in 2001/02. This downward trend is expected to continue given the aggressive targets set out in the regional health authorities' 2002/03 performance agreements.

PM#16 – Patient satisfaction rates

This indicator measures people's level of satisfaction with B.C. health care services in general and based on whether the health care service was received in a hospital, doctor's office, or community centre. This information helps to identify improvements from the patient's perspective and therefore supports accountability and a patient-centered health care system.

The bar charts on page 44 show that the majority of British Columbians who reported receiving any health care services in the past twelve months were generally satisfied with the way care was provided (86 per cent) and a majority rated the overall quality of the care they received as good or excellent (84 per cent).

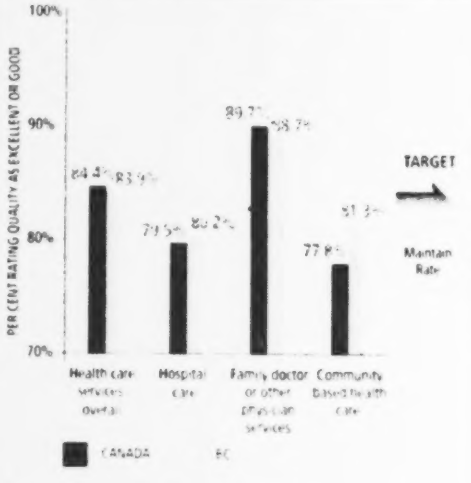
Eighty-one percent (81 per cent) of British Columbians who reported receiving hospital care in the past twelve months were satisfied with the way that care was provided and 80 per cent rated the quality of the care they received in hospital as good or excellent.

Ninety-one percent (91 per cent) of British Columbians who reported receiving care from a family doctor or other physician in

the past twelve months were satisfied with the way care was provided and 89 per cent rated the quality of the care they received from doctors as good or excellent.

Eighty-eight percent (88 per cent) of British Columbians who reported receiving community care in the past twelve months were satisfied with the way that care was provided and 81 per cent rated the quality of the community care they received as good or excellent.

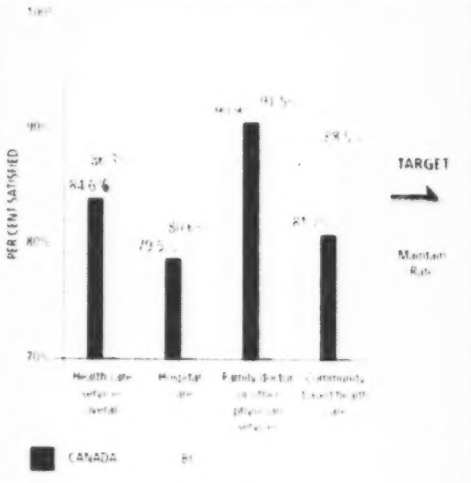
PATIENTS RATINGS OF THE QUALITY OF SELECT HEALTH CARE SERVICES



Source: Canadian Community Health Survey
(sub-sample approximately 25,000) Cycle 1.1, 2000

Notes:
1. Any Health Care Services: population aged 15 and over who reported receiving health care services in the past 12 months.
2. Hospital Care: population aged 15 and over who reported receiving hospital care in the past 12 months. This includes inpatient, outpatient and emergency room services.
3. Family Doctor or Other Physician: population aged 15 and over who reported receiving health care services from a family doctor or other physician, excluding those services which may have been received during a hospital visit.
4. Community based Health Care: population aged 15 and over who reported receiving community based health care in the past 12 months, excluding that received through a hospital or doctor's office. Examples of community based health care include home nursing care, home based counselling or therapy, personal care and community walk-in clinics.
5. Quality: Quality of health care services rated as excellent or very good.

PATIENTS SATISFACTION WITH SELECT HEALTH CARE SERVICES



Source: Canadian Community Health Survey
(sub-sample approximately 25,000) Cycle 1.1, 2000

Notes:
1. Any Health Care Services: population aged 15 and over who reported receiving health care services in the past 12 months.
2. Hospital Care: population aged 15 and over who reported receiving hospital care in the past 12 months. This includes inpatient, outpatient and emergency room services.
3. Family Doctor or Other Physician: population aged 15 and over who reported receiving health care services from a family doctor or other physician, excluding those services which may have been received during a hospital visit.
4. Community based Health Care: population aged 15 and over who reported receiving community based health care in the past 12 months, excluding that received through a hospital or doctor's office. Examples of community based health care include home nursing care, home based counselling or therapy, personal care and community walk-in clinics.
5. Satisfaction: Very or somewhat satisfied with health care services received.

Goal 2: Improved Health and Wellness for British Columbians

OBJECTIVE 5:
Reduce occurrence of preventable disease, illness and disability.

- PM#18 Incidence of selected communicable diseases (Hepatitis B, E.coli, and Cryptosporidiosis)
- PM#19 Potential Years of Life Lost (PYLLSR) due to cancer, cardiovascular disease and injuries
- PM#20 Immunization rates
- PM#21 Utilization of screening programs for at risk groups (screening mammography)
- PM#22 Smoking rates
- PM#23 Rates of healthy behaviors and conditions physically active and healthy body weight

OBJECTIVE 6:
Reduce inequalities in health status among specific populations in British Columbia.

- PM#24 Improved health status for Aboriginal peoples measured by infant mortality, life expectancy and PYLLSR

OBJECTIVE 7:
People have the information they need to stay healthy.

- Performance measure(s) to be developed.

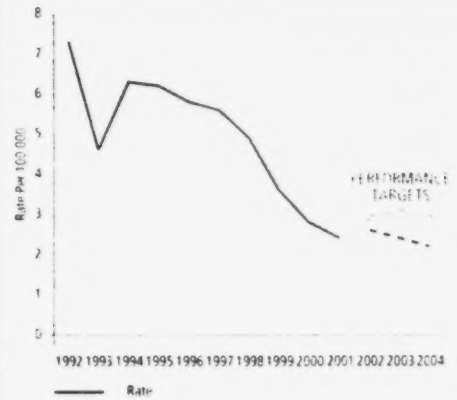
Goal

Objective

Performance Measure – Data included in report

Data not available

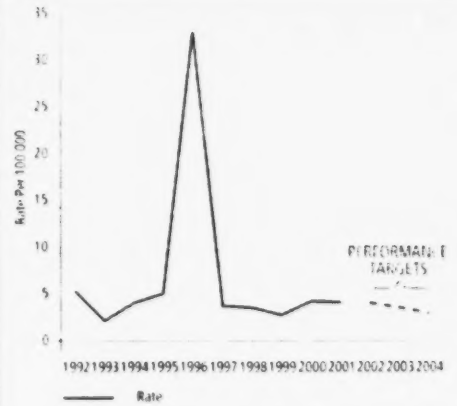
HEPATITIS B, B.C. 1992 – 2001



Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Rate	7.3	4.6	6.3	6.2	5.8	5.6	4.9	3.6	2.8	2.4	2.6	2.4	2.2
No. of Cases	255	163	232	233	224	221	197	143	113	98			

Source: Epidemiology Services, BC Centre for Disease Control

CRYPTOSPORIDIOSIS, B.C. 1992 – 2001



Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Rate	5.4	2.1	4.0	5.0	33.0	3.7	3.5	2.7	4.2	4.1	4.0	3.5	3.0
No. of Cases	187	74	149	189	1281	145	141	110	170	167			

Source: Epidemiology Services, BC Centre for Disease Control

Note: The changes in the incidence of this disease appear very high in the graph in the epidemic year but have usually been the highest cases in the province.

PM#18 – Incidence of selected communicable diseases (hepatitis B, cryptosporidiosis, *E. coli*)

This indicator measures the success of provincial health programs in preventing and controlling select communicable diseases.

Hepatitis B

The first of these indicators measures the incidence of acute hepatitis B. A decrease in the number of these cases is an important indicator of the effectiveness of the immunization program for this disease. Upon recognition of high disease rates in the province, the government introduced an immunization program in 1992 for Grade 6 students and high risk groups. In 2001, it expanded the program to include all infants.

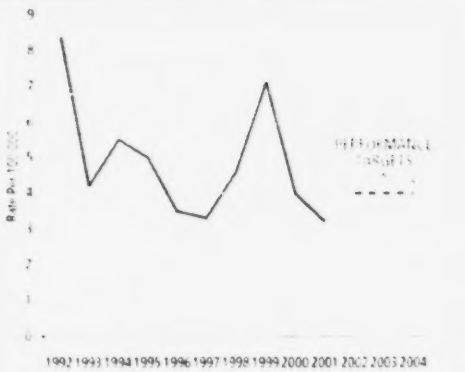
As the graph shows, the incidence of hepatitis B has been declining in recent years, particularly among young people who have benefited from immunization. The incidence has dropped from 5.6 reported cases per 100,000 population in 1997 to 2.4 reported cases per 100,000 in 2001. This indicator suggests that immunization programs have become more effective.

Cryptosporidiosis

The second of these indicators measures the occurrence of Cryptosporidiosis, which is primarily an indicator of drinking water quality and safety.

Following large water-borne disease outbreaks in 1996, disease rates have declined in recent years to the range of 2.7 to 4.1 reported cases per 100,000 population. However, environmental conditions in some drinking water systems continue to pose a risk of future outbreaks.

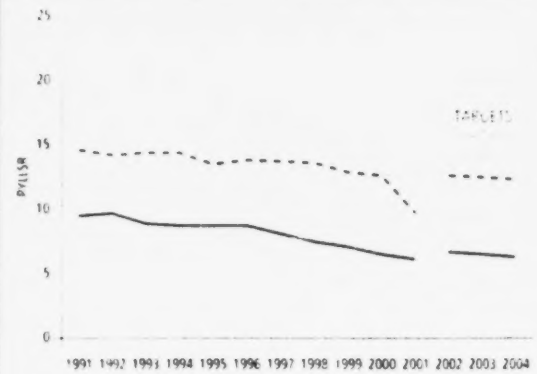
VERITOXIGENIC *E. COLI*, B.C. 1992 – 2001



Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Rate	8.4	4.2	5.5	5.0	3.5	3.3	4.6	7.0	4.0	3.2	4.0	4.0	4.0
No. of Cases	292	150	204	189	137	132	183	287	164	133			

Source: Epidemiology Services, BC Centre for Disease Control

POTENTIAL YEARS OF LIFE LOST STANDARDIZED RATE FOR SELECTED CAUSES, B.C. 1991 – 2001



Year	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
External Causes	14	15.6	20.5	19.2	17.8	17.3	17.4	16.3	14.2	12.9	12.1	14.5	13.9	13.6
Cardiovascular Disease	13.6	14.2	12.4	14.4	13.5	11.8	11.7	11.6	12.9	12.6	9.7	12.6	12.5	12.5
Cancer	9.5	9.7	8.9	8.7	8.7	8.7	8.1	7.5	7.1	6.5	6.1	6.7	6.5	6.3

Source: Epidemiology Services, BC Centre for Disease Control

Note: Potential Years of Life Lost Rate (PYLLSR) per 1,000 Standard population (Canada Census 1991)

Verotoxigenic *E. coli*

The third of these indicators measures the occurrence of Verotoxigenic *E. coli* (O157:H7), which is primarily a food-borne illness caused by unsafe food handling practices. It is a good indicator of the effectiveness of prevention efforts, including the promotion of safe food-handling practices.

Disease rates have varied in relation to the number and size of outbreaks. The incidence has declined in recent years to 3.2 reported cases per 100,000 population. This suggests that prevention efforts, including public awareness, are becoming more effective.

PM#19 – Potential years of life lost standardization rates (PYLLSR) due to cancer, cardiovascular disease and injuries

Potential Years of Life Lost (PYLL) focuses on premature deaths – deaths that occur in the younger age groups and that can, in theory, be prevented or at least postponed. PYLLSR, a generally accepted, overall indicator of population health, is a good measure of the effectiveness of prevention programs.

Cardiovascular disease, cancer, and injuries account for approximately two-thirds of total PYLL (cardiovascular disease: 15 per cent, cancer: 30 per cent, injuries: 22 per cent). Significant reductions are possible. For example, a one per cent reduction in blood cholesterol level or a 1 mmHg reduction in diastolic blood pressure in a population can each result in at two to three per cent decrease in the risk of cardiovascular disease. People who quit smoking can reduce their risk of heart attack by as much as 50 per cent. Cancer death rates can be reduced by efforts to reduce smoking (some estimates are 25 to 50 per cent), improve diets, screen for breast and cervical cancer, reduce sun exposure, and continue development and use of cancer treatments. Up to 90 per cent of injuries are preventable, if proven prevention methods are fully implemented.

Potential years of life lost standardized rates for all three mortality categories have

demonstrated general decreasing trends over the past decade, with the most significant improvements seen for external causes. This suggests that prevention programs are becoming more effective.

PM#20 – Estimated immunization rates

These indicators measure the coverage of selected immunization programs. Low rates may indicate a problem in access to or delivery of these highly effective health services.

A. Immunization Rates, Two-Year-Old Children

Immunization programs for children remain among the most cost-effective ways to improve health status and reduce health care costs. In British Columbia, all infants and preschool children have access to immunizations to protect them from nine serious diseases. These are: diphtheria, tetanus, polio, pertussis, haemophilus influenzae type b, mumps, measles, rubella, and hepatitis B. (Data on the hepatitis B immunization program, implemented in 2001, are not yet available for this age group.)

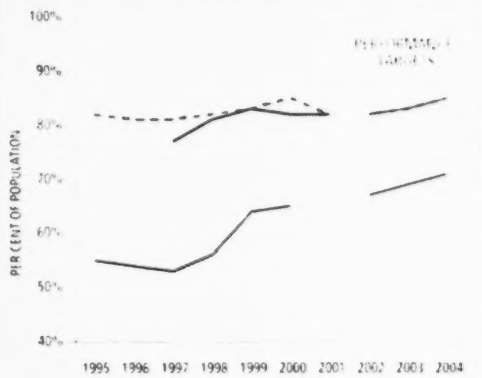
In 2001, about half of the health regions estimated that over 80 per cent of children had been fully immunized by their second birthday. Provincially, the reported immunization rates for two-year-olds, while relatively stable in recent years, decreased slightly in 2001 from 2000. For some areas of the province, immunization statistics remain unavailable due to various data collection and retrieval issues. The Ministry of Health Planning is reviewing methods to support improved data reporting in order to improve the accuracy of these estimates.

B. Influenza Immunization, Adults Aged 65 and Older

Influenza is a major cause of illness, hospitalization and death among older adults. Annual influenza vaccination reduces the risk of disease or may lessen the severity of illness. It also is effective preparation for an influenza pandemic, which is anticipated within the next five to ten years. Full implementation of the recommended influenza immunization program (80 per cent of adults aged 65 and older immunized) could prevent half of the deaths, hospitalizations and physician visits for influenza.

Provincially, an estimated 65 per cent of adults 65 years of age and older were immunized for influenza in 2000, which reflects a continued improvement in the vaccination rate (2001 data not yet available). This suggests that access to and delivery of these programs is improving.

ESTIMATED IMMUNIZATION RATES, CHILDREN AGED 2 YEARS AND ADULTS AGED 65+ YEARS, B.C., 1995 — 2001



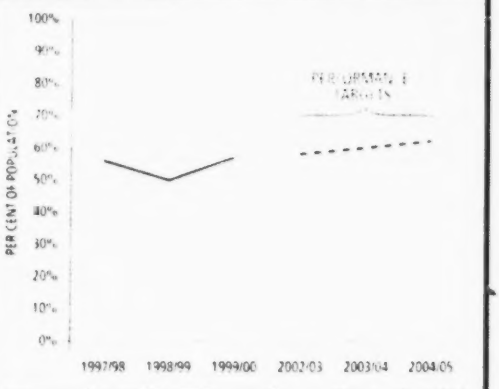
YEAR	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
DPTP	83%	81%	81%	83%	84%	84%	82%	82%	83%	85%
Hib	82%	81%	81%	82%	83%	85%	82%	82%	83%	85%
MMR/MR			77%	81%	83%	82%	82%	82%	83%	85%
Influenza	55%	54%	53%	56%	64%	65%		67%	69%	71%

Source: Disease and Injury Prevention Branch

Notes: Children aged 2 years
1. Complete data were not available for the following regions: Upper Island/Central Coast, South Fraser, Burnaby, Vancouver North, Sunshine
2. Statistics are determined from an audit of a one-month sample of Child Health Records done in April of each year
3. MMR = Measles Mumps Rubella or Measles Rubella (2 doses) Comparable data not available prior to 1997
4. DPTP = Diphtheria Pertussis Tetanus Polio (4 doses) Hib = Haemophilus influenza b (4 doses)

Adults aged 65+ years
1. Influenza vaccine. Provincial data excludes Vancouver and Capital Health Regions

SCREENING MAMMOGRAPHY ESTIMATED BIANNUAL SCREENING RATE, 1997/98 – 1999/00



YEAR	1997/98	1998/99	1999/00	2002/03	2003/04	2004/05
% OF POPULATION	56%	50%	57%	58%	60%	62%

Source: MSP Data, SMPBC Trends, Health Data Warehouse, Population data: BC Stats and Health Data Warehouse

Notes:
1. As biannual data is not currently available from MSP, the rate of bilateral mammography utilization during each of 2 year period is estimated by assuming the proportion of women who received bilateral mammography through MSP in both years are the same as that within SMP.
2. Based on the regional distribution of MSP exams, we assume that about 3 per cent of population receive bilateral mammograms through MSP for diagnostic rather than screening purposes. Thus, the overall annual and biannual screening rate is adjusted downwards by 3 per cent.
3. The estimate for biannual MSP volume is calculated by formulae: (MSP1st year + MSP2nd year – SMP2years - SMP1st year - SMP2nd year).
4. MSP data includes only MSP FFS item 8611 on female patients only, all out of province claims are excluded.
5. MSP data contains payment data to August 15, 2001 for services provided within fiscal year 2000/01.

PM#21 – Utilization of screening programs

A. Screening Mammography – Annual Summary

This indicator measures the use of mammograms to screen 50- to 74-year-old women annually for cancer, an important service for the early detection of illness. Reaching a larger proportion of the population is important in improving population health. Low utilization rates can indicate areas where women may have problems accessing this service.

Most screenings are provided through the Screening Mammography Program (SMP) of B.C. The number of screens provided by the program has increased each year since it began in 1988. Mammography services can also be provided through hospitals and x-ray facilities (billed through MSP).

The estimated annual rate of mammography screenings increased to 33 per cent of the target population in 1996. Since then, the rate has decreased slightly to 30 per cent of the target population in the year 2000. This is largely because in 1997 the SMPBC changed the screening interval recommendation for 50- to 79-year-old women to be at least once every two years instead of annually. However, the increasing trend of utilizing SMPBC for screening purpose is an encouraging step toward effective use of health care resources to improve population health.

B. Screening Mammography – Biannual Summary

This indicator measures the use of mammograms to screen 50- to 74-year-old women for cancer biannually or once every two years. The biannual screening rate for SMPBC is calculated based on the number of women who attended SMPBC during each two-year period. As each woman is counted only once, the biannual rate is smaller than the sum of the annual rates.

The estimated biannual screening rate for SMPBC has increased to 57 per cent in 1999/00.

PM#22 - Current Smoking Rates

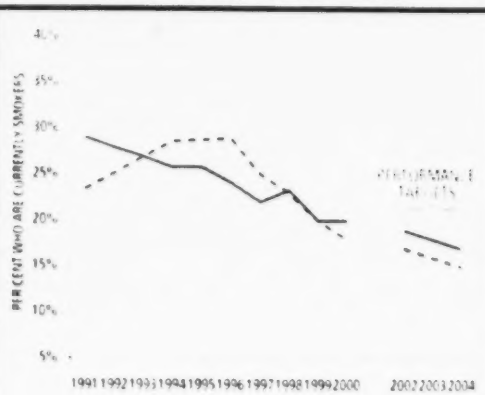
This indicator measures the proportion of the population who are current smokers (those who smoke cigarettes on either a daily or occasional basis).

Smoking is the most frequent cause of lung cancer and chronic respiratory disease, and also increases the risk of coronary heart disease, stroke, and Sudden Infant Death Syndrome (SIDS). While the provincial smoking rate has continued to decline over time as the provincial tobacco control strategy has implemented a comprehensive range of programs, some regions have higher rates than the provincial average.

based on a 1997 provincial survey. Other regions have attained prevalence rates at or below the provincial targets, indicating that reductions to the target level are possible to achieve. An emphasis on youth tobacco programming over the past five years has contributed to the significant drop in tobacco use rates among 15- to 19-year-olds. Comprehensive strategies elsewhere have achieved significant results.

The rate of smoking in B.C. is currently the lowest in Canada for the general population aged 12+ years and for youth population aged 15 to 19 years. For the year 2000, the rate is 20.5 per cent for the general population aged 12 and over and 16.5 per cent for youth aged 15 to 19. As the graph indicates, rates have been dropping since 1994. This suggests

CURRENT SMOKING RATES, AGES 15+ AND AGES 15-19, B.C., 1990 – 2001



YEAR	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2002	2003	2004
Ages 15-19	23%	25%	27%	29%	29%	28%	25%	23%	20%	16%	15%		
Ages 15+	29%	28%	27%	26%	25%	24%	22%	21%	20%	20%	18%	18%	17%

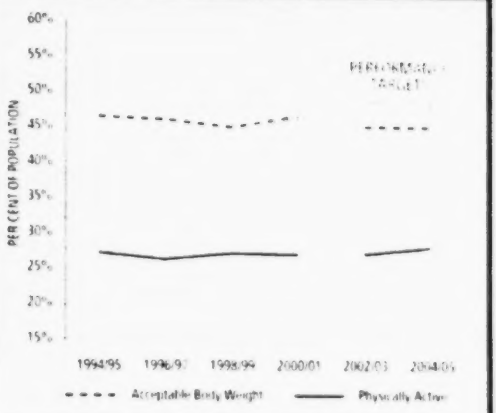
* Includes daily and occasional smoking

** Rates for ages 15-19 in earlier years are based on very small sample sizes and are less reliable. Angus Reid (1997) data are ages 15-18 years.

Source: Data for 1991: Stats Can GSS. Data for 1992: Angus Reid Tobacco Use in B.C. Survey. Data for 1994, 1996, and 1998: Stats Can NPHS. Data for 1999 and 2000: Health Canada CTUMS

Note: NPHS and Angus Reid data are ages 12+. CTUMS data are ages 15+.

PREVALENCE OF ACCEPTABLE BODY WEIGHT AND PHYSICAL ACTIVITY, B.C., 1994 – 2001



YEAR	1994/95	1996/97	1998/99	2000/01	2002/03	2004/05
Acceptable Body Weight	46.4%	45.9%	44.9%	46.4%	45.0%	45.0%
Physically Active	27.2%	26.2%	27.1%	26.9%	27.0%	28.0%

Source: Disease and Injury Prevention Branch

Notes: 1. Data from National Population Health Survey for 1994/95, 1996/97, and 1998/99; data from Canadian Community Health Survey for 2000/01.

2. Acceptable body weight means a Body Mass Index of 20.0 – 24.9 for people aged 20-64 years, excluding pregnant women.

3. Physically active is based on responses to questions about the frequency, duration, and intensity of participation in leisure-time physical activity, for people aged 12+ years.

that the provincial programs to reduce smoking have been effective.

PM#23 – Rates of healthy behaviours and conditions prevalence of acceptable body weight and physical activity

This indicator measures the percentage of the population that has an acceptable body weight and who are physically active. These rates provide information about the success of policies and programs to promote a healthy lifestyle.

BMI (Body Mass Index) is an indicator of obesity and therefore an indicator of risk for chronic disease in the adult population, particularly heart disease and diabetes. The percentage of British Columbians aged 20 to 64 years (excluding pregnant women) who are maintaining an acceptable BMI has remained stable at about 45 per cent in recent years. Research indicates a trend

towards increasing obesity across North America and therefore, the future performance target is focused on maintaining the prevalence of acceptable body weight at 45 per cent.

Physical inactivity is a risk factor for chronic diseases such as heart disease, diabetes, and some cancers. The level of physical activity is an indicator of population risk for future chronic illness. The percentage of British Columbians, 12 years-of age and older who are physically active during their leisure time has remained stable at about 27 per cent in recent years. Therefore, the future performance target is to increase the percentage of the population who are physically active enough to achieve health benefits.

PM#24 – Improved health status of Aboriginal peoples

This indicator measures infant mortality and life expectancy rates and potential years of life lost for Aboriginal peoples. As a group, they have a level of health that falls below that of the general population. It also reflects the success in reducing this long-standing gap in health status.

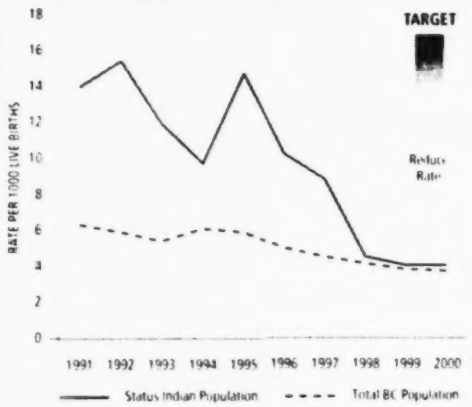
A. Status Indian Infant Mortality Rates

The infant mortality rate for the status Indian population in the province ranged from a high of 15.4 to a low of 4.0 over the years 1991 to 2000. The 2000 rate of 4.0 infant deaths per 1,000 live births was only slightly greater than the overall provincial rate of 3.7. This is a vast improvement over rates that were more than double the provincial rate in the early 1990s.

B. B.C. and Status Indian Life Expectancy

Life expectancy is an estimate of the average number of years that a person born in that year is expected to live, based on current mortality rates. For British Columbians, life expectancy (five-year average) has risen steadily in the last decade from 78.6 to 79.9 in the general population, and from 69.0 to 72.3 in the status Indian population. Although still less than the general

INFANT MORTALITY RATES – BRITISH COLUMBIA STATUS INDIAN POPULATION, 1991 – 2000

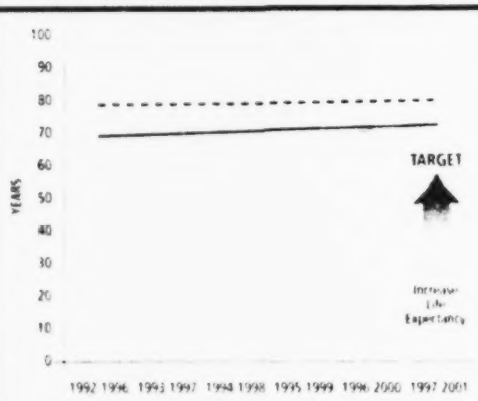


YEAR	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Status Indian Population										
Total BC Population										

Source: BC Vital Statistics Agency (Status Indian info); BC Stats (BC population)

Note: Rates are per 1,000 live births in the specified area

LIFE EXPECTANCY — BRITISH COLUMBIA STATUS INDIAN POPULATION, 1991 — 2000



YEAR	1992/96	1993/97	1994/98	1995/99	1996/00	1997/01
Status Indian Population	69.0	69.8	70.5	71.2	71.7	72.3
Total BC Population	78.6	78.9	79.0	79.2	79.5	79.9

Source: BC Vital Statistics Agency (Status Indian info); BC Stats (BC population)

Note: Rates are per 1,000 live births in the specified area

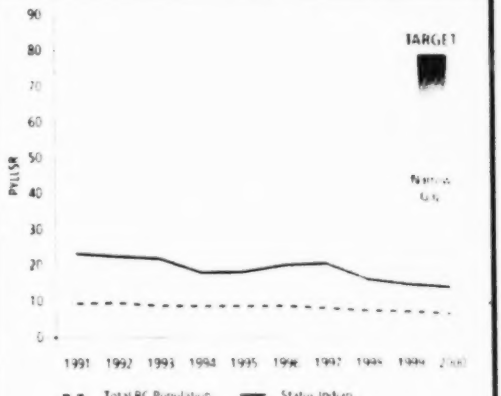
population, the gap in life expectancy between the status Indian and general populations has decreased slightly in the last decade.

C. B.C. and Status Indian Potential Years of Lost Life Standardized Rates (PYLLSR)

Potential Years of Life Lost (PYLL) focuses on premature deaths – deaths that occur in the younger age groups and that can, in theory, be prevented or at least postponed. PYLLSR, a generally accepted, overall indicator of population health, also measures the effectiveness of prevention programs. Cardiovascular disease, cancer, and injuries account for approximately two-thirds of total PYLL (cardiovascular disease - five per cent, cancer – 30 per cent, injuries – 22 per cent). Significant reductions are possible.

Potential years of life lost standardized rates for all three mortality categories have demonstrated general decreasing trends over the past decade, with the most significant

POTENTIAL YEARS OF LIFE LOST DUE TO CARDIOVASCULAR DISEASE (I00-I99), BRITISH COLUMBIA STATUS INDIAN POPULATION, 1991 — 2000

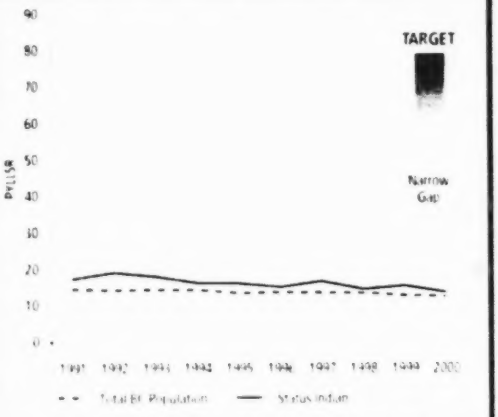


YEAR	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Status Indian Population	23.4	22.7	22.0	18.1	18.3	20.2	20.6	16.2	14.7	13.9
Total BC Population	9.5	9.7	8.9	8.7	8.7	8.7	8.1	7.5	7.1	6.5

Source: BC Vital Statistics Agency (Status Indian info)
BC Stats (BC population)

Note: Potential Years of Life Lost Rate (PYLLSR) per 1,000 Standard population (Canada Census 1991)

POTENTIAL YEARS OF LIFE LOST DUE TO CANCER BRITISH COLUMBIA STATUS INDIAN POPULATION, 1991 — 2000 AGE STANDARDIZATION

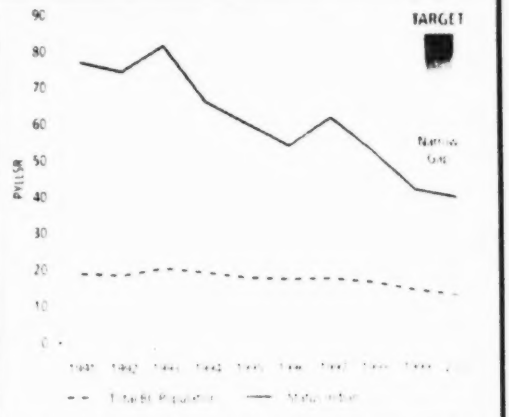


YEAR	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Status Indian Population	17.4	19.2	18.1	16.3	16.2	15.2	16.8	14.6	15.6	13.7
Total BC Population	14.6	14.2	14.4	14.4	13.5	13.8	13.7	13.6	12.9	12.5

Source: BC Vital Statistics Agency (Status Indian info)
BC Stats (BC population)

Note: Potential Years of Life Lost Rate (PYLLSR) per 1,000 Standard population (Canada Census 1991)

POTENTIAL YEARS OF LIFE LOST DUE TO EXTERNAL CAUSES (V01-Y98), BRITISH COLUMBIA STATUS INDIAN POPULATION, 1991 — 2000



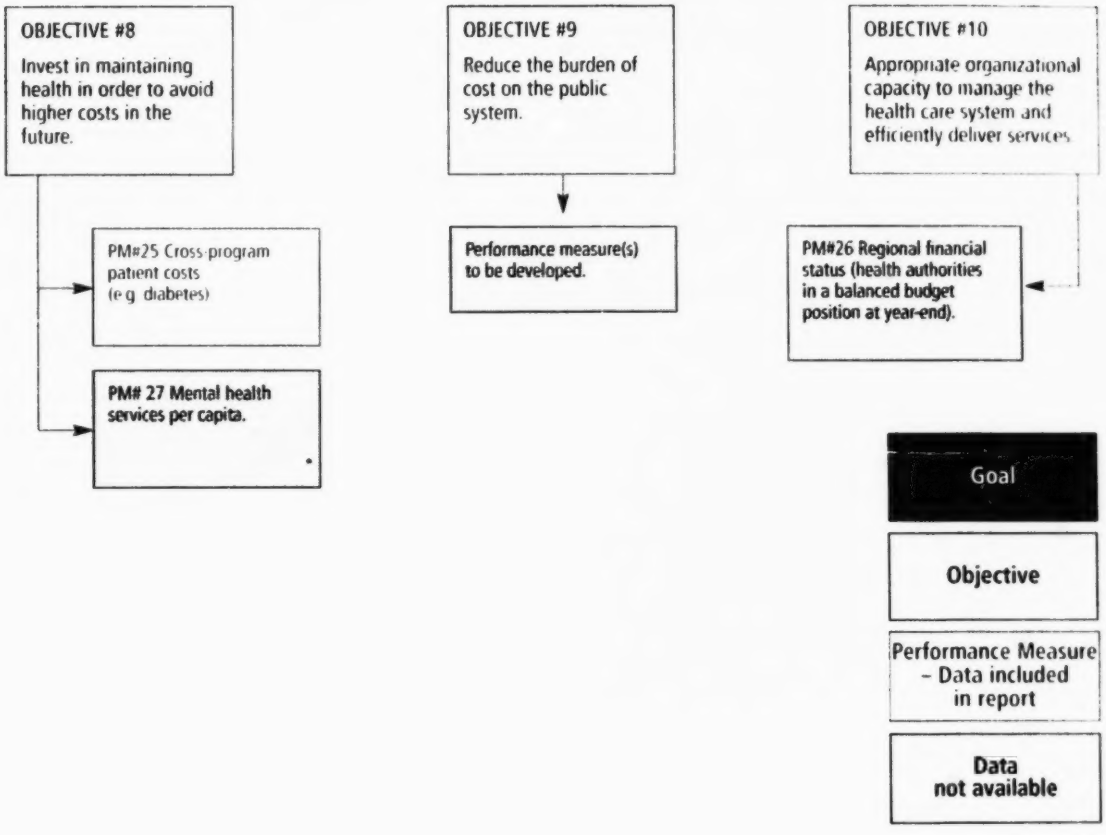
YEAR	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Status Indian Population	77.2	74.5	81.6	66.2	60.2	54.0	61.7	52.5	41.8	44.6
Total BC Population	19.0	18.6	20.2	19.2	17.8	17.3	17.4	16.3	14.2	12.8

Source: BC Vital Statistics Agency (Status Indian info)
BC Stats (BC population)

Note: Potential Years of Life Lost Rate (PYLLSR) per 1,000 Standard population (Canada Census 1991)

improvements seen for external causes. This pattern holds true for both the general population and the status Indian population; however, the premature mortality rate for the status Indian population was more than four times greater than the general population for external causes and double that of the general population for cardiovascular diseases. Status Indian premature mortality rates from cancers were marginally higher than those of the general population over the time period.

Goal 3: A Sustainable, Affordable Public Health System


OBJECTIVE #8
Invest in maintaining health in order to avoid higher costs in the future.
PM#25 Cross-program patient costs (e.g. diabetes)
PM# 27 Mental health services per capita.
OBJECTIVE #9
Reduce the burden of cost on the public system.
Performance measure(s) to be developed.
OBJECTIVE #10
Appropriate organizational capacity to manage the health care system and efficiently deliver services.
PM#26 Regional financial status (health authorities in a balanced budget position at year-end).
Goal
Objective
Performance Measure – Data included in report
Data not available

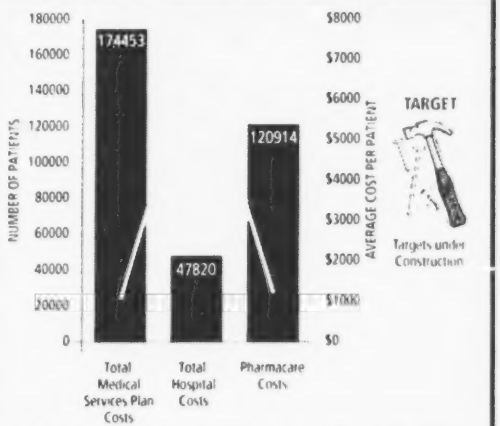
PM#25 – Cross-program patient costs

This indicator measures the average health care cost per patients with diabetes. Diabetes is a chronic disease that affects about five per cent of Canadians. Its prevalence is expected to increase significantly due to an aging population and increased rates of obesity. Efforts to control hyperglycemia, hypertension and dyslipidemia can prevent or postpone the development of complications in persons with diabetes. The B.C. diabetes guidelines, which have been adopted and shared with physicians and patients, outline strategies to help the primary care practitioner meet the complex needs of persons with diabetes.

It is anticipated that adherence to the guideline will result in better patient care and, eventually, lower per-patient cost. Therefore, this indicator helps to measure the cost-efficiency of standardized practices of care.

Data for 2001/02 reveal that total health costs (MSP, Hospital and Pharmacare costs not limited to diabetes-related treatment) for the 174,453 patients on the Diabetes Registry amounted to $683,921,627. The following table shows how these costs were distributed.

PAID AMOUNTS ASSOCIATED WITH DIABETES REGISTRY PATIENTS FOR 2001/02



PAID AMOUNTS ASSOCIATED WITH DIABETES REGISTRY PATIENTS FOR 2001/02

	Number of Patients	Total Costs	Average Cost Per Patient
Medical Services Plan	174,453	$183,842,940	$1,054
Hospital	47,820	$254,169,168	$7,406
Pharmacare	120,914	$145,909,519	$1,207

Source: MSP Economic Analysis Branch, Pharmcare, Standards and Performance Development, Population Health Surveillance and Epidemiology Branch

Notes:
1. The analysis was based on individuals who:
   a) received 2+ physician services on different dates paid by MSP within 365 days coded 250 (diabetes mellitus) since 1991, or
   b) had 1+ hospital discharges coded 250 since 1991, or
   c) received insulin, oral hypoglycaemics, or testing strips paid for in part by Pharmacare since 1991, and
   d) received one or more MSP-paid service in 2001/02 fiscal year.
2. MSP cost is the total amount paid for MSP services to individuals on the diabetes registry who received at least one or more MSP-paid services in 2001/02. It excludes ICBC reciprocal, and out-of province claims. It includes services paid to May 15, 2002.
3. Hospital costs consist of all acute, rehabilitation, and day care separations for the relevant Diabetes Registry patients (see note 2). Costs are based upon a $3500/RIW (resource intensity weight).
4. Pharmacare costs include all non-hospital prescription activity paid for by Pharmacare for the relevant Diabetes Registry patients.

REPORT ON RESOURCES

MINISTRY OF HEALTH SERVICES 2001/02 RESOURCE SUMMARY

(Note 1)

	ESTIMATED	OTHER AUTHORIZATIONS	TOTAL	ACTUAL	VARIANCE	NOTE
OPERATING EXPENSES ($000)						
REGIONAL PROGRAMS						
Adult Mental Health	405,630		405,630	391,835	13,795	2
Public and Preventive Health	356,131		356,131	340,731	15,400	2
Acute and Continuing Care	5,182,618		5,182,618	5,331,619	(149,001)	2
Subtotal	5,944,379	–	5,944,379	6,064,185	(119,806)	2
Emergency Health	181,036		181,036	182,087	(1,051)	3
Medical Services Plan	2,262,488	230,000	2,492,488	2,366,676	125,812	4, 5
Pharmacare	719,150		719,150	716,984	2,166	6
CORPORATE SERVICES						
Information Management Group	55,853		55,853	57,992	(2,139)	
Corporate Programs	7,907		7,907	7,670	237	
Strategic Programs	40,776		40,776	37,183	3,593	
Other Corporate Services	4,466		4,466	1,615	2,851	
Subtotal	109,002	–	109,002	104,460	4,542	7
Other	297,258	1	297,259	280,316	16,943	8
Total	9,513,313	230,001	9,743,314	9,714,708	28,606	9
FULL-TIME EQUIVALENTS (FTES)						
Total	3,533	–	3,533	3,415	118	10
MINISTRY CAPITAL EXPENDITURES ($000)						
Information Systems	15,724		15,724	10,464	5,260	11
Specialized Equipment	3,510		3,510	2,111	1,399	
Vehicles	6,650		6,650	6,870	(220)	
Office Furniture and Equipment	620		620	176	444	
Total	26,504	–	26,504	19,621	6,883	
CONSOLIDATED CAPITAL PLAN EXPENDITURES ($000)						
Health Facilities Projects and Equipment	274,000		274,000	168,550	105,450	12
Total	274,000	–	274,000	168,550	105,450	
OTHER FINANCING TRANSACTIONS (NET DISBURSEMENTS) ($000)						
Health Innovation Incentive Program	5,624		5,624	2,079	3,545	13
Total	5,624	–	5,624	2,079	3,545	

Notes

1) Estimated budget, other authorizations and actual amounts for 2001/02 as per draft Public Accounts. Figures are unaudited.

2) Regional Programs – Overexpenditure due to one time funding provided to health authorities to offset their projected deficits for 2001/02, partially offset by one time savings in other areas.

3) Emergency Health Services – Overexpenditure due to call volume increases.

4) Medical Services Plan – Other authorizations amount represents the additional funding obtained through Supplementary Estimates for the costs associated with the interim physician arbitration award.

5) Medical Services Plan – Underexpenditures in various areas, including primary care, rural health and alternative payments, and savings associated with implementation of supplemental benefits.

6) Pharmacare – Minor one time savings in Seniors Plan.

7) Corporate Services – Underexpenditure primarily due to recruitment lag and other one time savings.

8) Other includes Amortization of Prepaid Capital Advances, Debt Service Costs, Vital Statistics, Minister's Office and Special Accounts, as well as statutory spending for collective agency commissions, offset by additional authorizations. Surplus due to stronger than expected sinking fund earnings, which reduced debt service costs.

9) The structure of the health ministries has changed significantly since the 2001/02 budget was tabled in the Legislative Assembly on July 30, 2001. By necessity, the public accounts reflect the results of operations against the budget approved by the Legislative Assembly for 2001/02, and those figures are reflected in the ministries' annual reports for the year. For the 2002/03 fiscal year, the budget reflects the new organizational structure and mandate.

10) FTEs – underutilization due to recruitment lag.

11) Ministry Capital Expenditures – Underspending due to lower than budgeted capital spending in 2001/02 in general, for information systems, deferral or cancellation of systems capital projects resulting from changes in focus and business priorities.

12) Consolidated Capital Plan Expenditures – variance due to lower than budgeted capital spending in 2001/02, resulting from ministry and health authority review of capital projects for affordability and priority in regard to health authority restructuring.

13) Health Innovation Incentive Program – variance due to reduced utilization of program in 2001/02.

REVENUES

ACTUAL VERSUS ESTIMATED GROSS REVENUES

	2001/02	
	Estimated Revenue	Actual Revenue
Medical Services Plan	$903,661,000	$955,761,000
BC Ambulance Services	$24,334,000	$25,992,000
Vital Statistics Agency	$10,133,000	$9,929,000
Other	$43,509,000	$55,125,000
Total	$981,637,000	$1,046,807,000

MSP Premiums Receivable - Turnover and Days Billing Uncollected

Accounts receivable turnover is one indication of the timeliness of collection. Accounts receivable turnover for MSP Premiums was 6.33 times for fiscal year 2001/02; 8.78 times for fiscal year 2000/01; 10.4 times for fiscal year 1999/00; 11.6 times for fiscal 1998/99.

Days billings uncollected is another indication of the speed of collecting accounts receivable. 2001/02 – 57 days; 2000/01 – 42 days; 1999/00 – 35 days.

*Collections and Credit Adjustments include Premiums paid and adjustments that reduce indebtedness.

MEDICAL SERVICES PLAN

Collection of Overdue MSP Premiums Receivable

FISCAL YEAR	TOTAL REVENUE	COLLECTIONS NOTICES	COLLECTIONS AND CREDIT ADJUSTMENTS*
2001/02	$955,761,000	$87,939,297	$47,204,936
2000/01	895,601,000	41,349,948	64,095,630
1999/00	868,263,000	48,760,327	82,900,912
1998/99	876,047,000	60,495,000	44,242,000
1997/98	881,826,000	54,384,000	33,652,000

Aging of MSP Premiums Receivable

FISCAL YEAR	TOTAL	CURRENT	30-60 DAYS	60-90 DAYS	OVER 90 DAYS
March 31, 2002	$148,458,499	$20,411,685	$16,700,625	$4,427,883	$106,918,306
March 31, 2001	101,978,114	29,314,594	9,651,327	3,428,428	59,583,765
March 31, 2000	83,159,816	27,728,253	7,045,567	3,482,546	44,903,450
March 31, 1999	75,680,927	12,161,511	7,454,562	2,725,694	53,339,160
March 31, 1998	54,246,519	13,015,195	9,187,698	1,679,532	30,364,094

Notes

1. Private collection agencies were used as of January 2001 to July 2001 for premiums and from April 2001 to September 2001 for ambulance fees.
2. The Ministry has recognized the increase in accounts receivable for 2000/01 and has introduced payment plans. The Collection and Loans Management Branch became the Ministry collection agency in July 2001 for premiums and October 2001 for ambulance fees.
3. Restated balance from 1999/00.
4. Value of current outstanding accounts receivable and total accounts receivable are as a result of the paramedic job action which resulted in a delay for producing and mailing billing statements.
5. Total Premiums Receivable have been adjusted to include post closing entries.

BC AMBULANCE SERVICES

Collection of Overdue Ambulance Service Fees

FISCAL YEAR	TOTAL REVENUE	COLLECTIONS NOTICES
2001/02	$25,992,000	15,206,168
2000/01	22,195,281	11,712,737
1999/00	24,372,818	10,272,287
1998/99	23,496,000	13,349,000
1997/98	22,445,000	9,542,000

Aging of Ambulance Fees Receivable

FISCAL YEAR	TOTAL	CURRENT	30-60 DAYS	60-90 DAYS	OVER 90 DAYS
March 31, 2002	$26,021,489	$11,285,126	$756,255	$657,635	$13,322,473
March 31, 2001	22,346,391	10,387,579	855,755	327,171	10,775,886
March 31, 2000	11,047,934	1,796,950	913,085	386,409	7,951,490
March 31, 1999	9,488,913	1,265,355	408,006	308,543	7,507,009
March 31, 1998	10,344,927	2,575,413	954,471	380,966	6,434,077

Ambulance Service Fees Receivable – Turnover and Days Billings Uncollected

Accounts receivable turnover is one indication of the timeliness of collection. Accounts receivable turnover for Ambulance Service Fees Receivable was 1.0 times for fiscal year 2001/02, 1.0 times for fiscal year 2000/01, and 2.2 times for fiscal year 1999/00. Accounts receivable turnover for 2000/01 and 2001/02 is low as a direct result of delays in producing and mailing billing statements due to paramedic job action.

Days billings uncollected is another indication of the speed of collecting accounts receivable. 2001/02 – 365 days; 2000/01 – 365 days; 1999/00 – 166 days.

Collection Program Costs

	2001/02	2000/01	1999/00	1998/99
Collection Dept Costs	$700,000	$750,000	$750,000	$750,000
Collection & Loan Management Branch	828,535	205,000	155,000	175,758
Collection Agency Commissions	417,836	910,056	499,666	235,164
Total Collection Costs	$1,946,371	$1,865,056	$1,404,666	$1,160,922

Notes

1 Private collection agencies were used as of January 2001 to July 2001 for premiums and from April 2001 to September 2001 for ambulance fees.

2 The Ministry has recognized the increase in accounts receivable for 2000/01 and has introduced payment plans. The Collection and Loans Management Branch became the Ministry collection agency in July 2001 for premiums and October 2001 for ambulance fees.

3 Restated balance from 1999/00.

4 Value of current outstanding accounts receivable and total accounts receivable are as a result of the paramedic job action which resulted in a delay for producing and mailing billing statements.

5 Total Premiums Receivable have been adjusted to include post closing entries.

CAPITAL PROJECTS

A wide range of capital construction projects was undertaken to provide new and improved health care facilities for British Columbians. Major projects undertaken by the health authorities in 2001/02 included:

FRASER HEALTH AUTHORITY

Funding of $210 million was approved for the Fraser Valley Health Centre and the Eastern Fraser Valley Cancer Centre. In August 2001 the Fraser Health Authority and the Provincial Health Services Authority initiated a review of the Business Case to examine the possibilities for increased participation of the private sector in the design, development and operations of the new facilities.

The $1.5 million 16 bed hospice at St. Michael's Hospital in Burnaby completed in March 2002.

VANCOUVER COASTAL HEALTH AUTHORITY

Work is continuing on the $156.4 million Vancouver General Hospital redevelopment project with construction starting on floors 4 to16 of the Nursing Tower. Three of the fifteen components of the project completed in 2001. The components included an interim boiler upgrade, an elevator to the heliport and HVAC upgrade.

The $14.7 million SUCCESS Care Home opened in October 2001. The new facility has 103 multi-level care beds.

PROVINCIAL HEALTH SERVICES AUTHORITY

Construction completed on the new $22.3 million Ambulatory Care Building and Emergency Expansion at B.C. Children's Hospital in March 2002. The new unit is designed to meet the increasing demand for clinic and day surgery services. The five-story building will provide more patient and family amenities such as breastfeeding rooms, quiet rooms, change rooms and expanded waiting rooms with play areas.

Connolly Lodge, a 20 bed mental health residential care facility on the Riverview site, opened in March 2002. The $1.6 million facility will provide 24-hour supervised care to clients who can benefit from greater independence and do not require hospitalization.

INTERIOR HEALTH AUTHORITY

The $1.6 million 10 bed multi-level care addition at the Royal Victoria Hospital in Kaslo completed in July 2001.

The new $6.6 million South Similkameen Health Centre & 25 bed multi-level care facility opened in Keremeos in 2001.

NORTHERN HEALTH AUTHORITY

The $6.3 million infrastructure upgrade at Fort St. John Hospital completed in January 2002.

The $38.3 million Kitimat Hospital and Health Care Centre completed in March 2002. The new facility includes 22 acute care beds, maternity, day surgery, ambulatory care, diagnostic imaging, laboratory, pharmacy, rehabilitation, community health services, adult day centre and administrative support.

The new multi-level care building will include an Adult Day Care component and 36 multi-level beds.

Construction of the Detox-Assessment and Treatment Centre for Women and Children in Prince George completed in September 2001. The new $4.5 million centre includes three separate areas for women, youth and women with children.

Iris House, the new specialized mental health facility on the grounds of Prince George Regional Hospital, completed in March 2002. The $1.3 million 10-bed home-like facility will help house and care for people with serious or persistent mental illness, providing assessment, treatment and rehabilitation.

Construction continues on the $50 million phase one of the expansion and redevelopment at the Prince George Regional Hospital. This major project includes a four-story medical surgical tower, additional new out-patient services and an upgraded emergency department.

VANCOUVER ISLAND HEALTH AUTHORITY

A new $1.5 million Canadian Red Cross Outpost Hospital in Bamfield completed construction in November 2001.

The new $6.2 million Cormorant Island Health Centre in Alert Bay opened in March 2002. The new hospital replaced St. George's Hospital and will provide acute-care, multi-level care, diagnostic and treatment facilities, community health programs and support services.

Yuculta Lodge in Campbell River opened in October 2001. The $10.9 multi-level care facility has 100 new beds.

The $37.9 million West Coast General Hospital and $4.3 million multi-level care facility completed in August 2001. The new acute care facility replaces the hospital built in the early 1950's. The multi-level care facility has 32 beds.

The $116 million diagnostic and treatment redevelopment project at Royal Jubilee Hospital in Victoria completed in March 2002. The diagnostic and treatment centre includes diagnostic imaging, laboratory, pharmacy, cardiology, emergency, intensive care and coronary care unit.

Construction is continuing on the $31.1 million Mount Saint Mary's 200 bed multi-level care facility in Victoria.

Equipment

Capital and operating funding of $63 million was approved to help hospitals buy diagnostic equipment such as CT scanners, modern clinical equipment for operating rooms and labs, and new beds and lifts to prevent injuries to health care workers.

APPENDIX 1 – ACTS UNDER THE JURISDICTION OF THE MINISTER OF HEALTH SERVICES

Access to Abortion Services Act

Anatomy Act

BC Benefits (Income Assistance), insofar as it authorizes the Healthy Kids Orthodontia Program

Community Care Facility Act

Continuing Care Act

Drinking Water Protection Act

Forensic Psychiatry Act

Health Act, except ss. 2 to 7

Health and Social Services Delivery Improvement Act, except Part 3

Health Authorities Act

Health Care (Consent) & Care Facility (Admission) Act

Health Emergency Act, except ss. 6 – 9, 14 (2)(a) and (b)

Health Special Account Act

Hospital Act

Hospital District Act

Hospital Insurance Act

Human Tissue Gift Act

Meat Inspection Act

Medicare Protection Act, except ss. 3 – 6

Mental Health Act

Milk Industry Act, s. 12, except in respect of tank milk receiver licences

Ministry of Health Act

Pharmacists, Pharmacy Operations and Drug Scheduling Act, ss. 37 – 39

Public Toilet Act

Venereal Disease Act

APPENDIX 2 – 2001/02 LEGISLATIVE CHANGES

Four Acts, three administered by the Ministry of Health Services and one administered by the Ministry of Health Planning, were amended or enacted during the 2nd and 3rd Legislative Sessions of the 37th Parliament in 2001 and the first quarter of 2002.

Ministry of Health Services

HEALTH AUTHORITIES AMENDMENT ACT (NO. 2), 2001

(BILL 9, 2nd Session)

This Bill repealed provisions of the *Health Authorities Act* and the *Expropriation Act* that allowed for the mandatory amalgamation of a private corporation with a health authority without compensation.

HEALTH AND SOCIAL SERVICES DELIVERY IMPROVEMENT ACT, 2002

(BILL 29, 2nd Session)

This Bill enabled health employers to deliver cost effective and improved services to the public by

- facilitating implementation of new health authorities restructuring,
- permitting more flexible work arrangements,
- removing excessive layoff and bumping provisions, and
- allowing improved service delivery through open tendering.

MEDICAL SERVICES ARBITRATION ACT, 2002

(BILL 9, 3rd Session)

This Bill cancelled the arbitration between the government and the British Columbia Medical Association and discontinued all further rights and obligations under the arbitration. It also declared as void or amended specific contractual provisions respecting interest arbitration.

Ministry of Health Planning

MISCELLANEOUS STATUTES AMENDMENT ACT, 2001

(BILL 11, 2nd Session)

This Bill repealed certain provisions of the *Medical Practitioners Act* pertaining to the practice of complementary medicine by medical practitioners where those provisions:

- restricted the College's ability to evaluate applicants for admission where the applicant supports the use of complementary medicine;
- limited the circumstances in which an investigation committee could be appointed to examine the skills of knowledge or a practitioner;
- restricted the ability of an inquiry committee in a disciplinary matter to make findings with respect to a practitioner who used complementary medicine.

The Bill also amended the Act to provide that the practice of a non-conventional therapy by a member is not by itself a basis for holding that the member is incompetent or guilty of professional misconduct unless it can be shown that the therapy poses a greater risk to patient health or safety than does prevailing medical practice.

APPENDIX 3 – MINISTRY ORGANIZATIONAL CHART FOR MARCH 2002